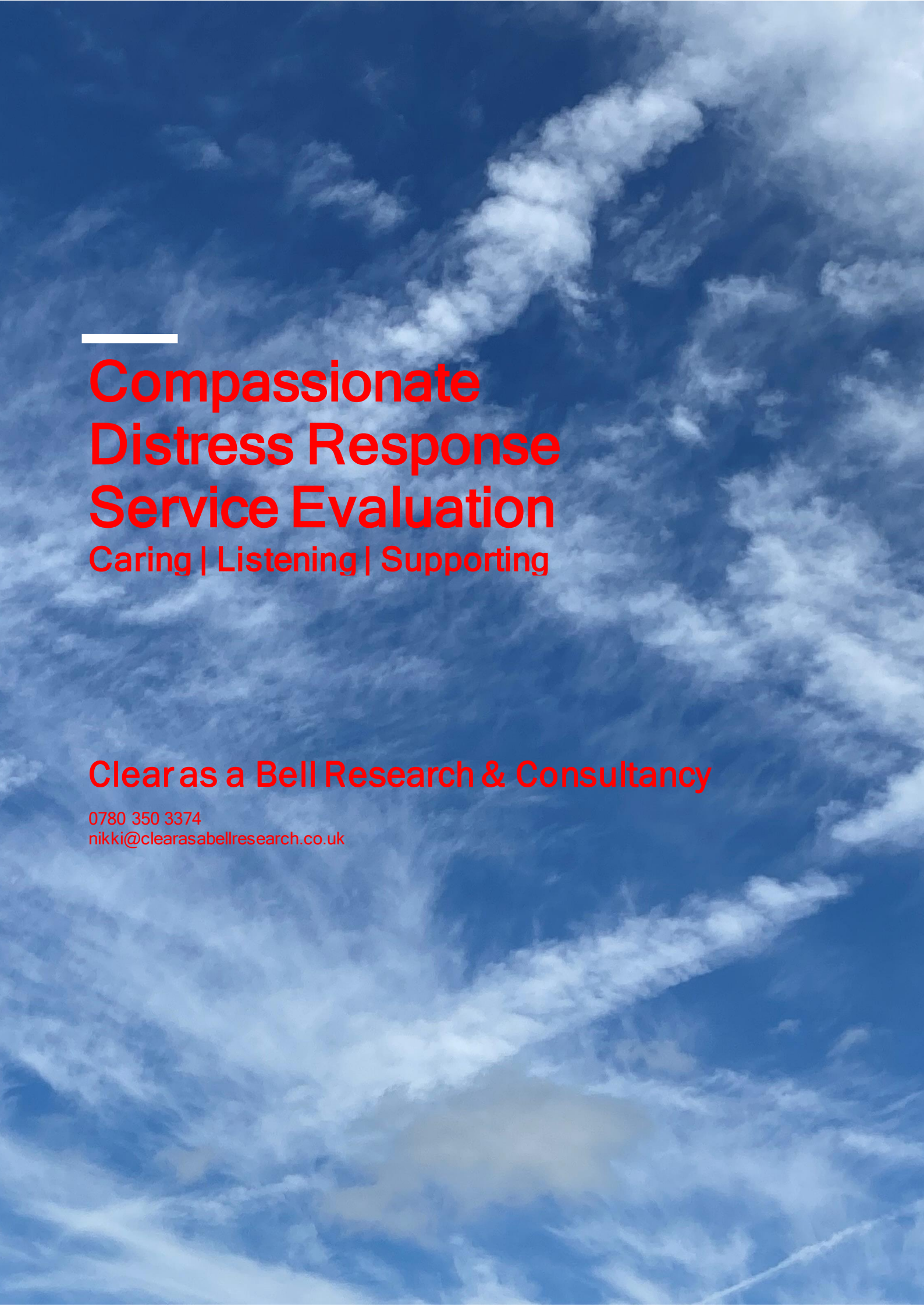

Compassionate Distress Response Service Evaluation

Caring | Listening | Supporting

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Acknowledgements

I would like to take this opportunity to thank the many people who have taken part in this evaluation. This includes people who have used the CDRS service, those who have referred to it, the CDRS team, GAMH management, the steering group and other key stakeholders.

This was a big ask of those who had used the service, but you all took the time to share your experiences and this was hugely appreciated. I know how precious time was for referrers, the team and other stakeholders and thank you for your generosity. The feedback provided by you all was invaluable to the evaluation and there were many interesting discussions!

I hope the information shared within this report helps to inform future development of a much-needed service.

Nikki Bell
Clear as a Bell

December 2022

Photograph on front cover © Nikki Bell

Executive Summary

INTRODUCTION

Glasgow City Health and Social Care Partnership (GCHSCP) commissioned this evaluation of the Compassionate Distress Response Service (CDRS) in autumn 2021. CDRS is run by Glasgow Association for Mental Health (GAMH) to provide support to people in emotional distress. Support is provided largely by phone and consists of compassionate listening, safety planning, tools and techniques to help equip people to cope with their distress and signposting or referrals to other services of assistance. It provides a non-clinical, person-centred response.

CDRS has three distinct services: Out of Hours (OOH), In Hours (IH) and a Young People's Service. This evaluation only considers the OOH and IH services. The OOH service was commissioned first and took its first referrals in May 2020. It operates seven day a week, 5pm to 2am for anyone in distress in Glasgow City at the time of their distress. It takes referrals from Mental Health Assessment Units (MHAUs), Emergency Departments, Out of Hours CPNs and GPs, Scottish Ambulance Service, Police Scotland, Psychiatric Liaison, Mental Health Triage Car, British Transport Police, Social Work Standby and will respond within an hour. The IH service took its first referrals in September 2020 and all referrals are from General Practices. This service operates 9am – 5pm, Monday to Friday and will respond within 24 hours.

The evaluation sought to understand the impacts on those who receive support and those who refer to CDRS by profiling who uses the service, understanding the pathways for access, articulating the input provided and describing the cost of the service as it relates to outcomes.

THE APPROACH

The project was overseen by a contract management steering group and consisted of:

- a brief literature review to set the context for the service;
- a review of existing data held by CDRS; and
- primary research with CDRS staff members (14), people who had used the service (9), those who had referred into the service (42) and other relevant stakeholders (5) – a total of 70 individuals gave their views.

KEY FINDINGS

Profile of referrals

- The dataset analysed for the evaluation consisted of all referrals logged by 4th February 2022, a total of 5,050 cases (1,737 for OOH and 3,313 for IH). Referrals for each service grew steadily until June 2021 when they became more consistent.
- Two-thirds of referrals to the Out of Hours service came from the MHAUs.
- The postcode G20 (Maryhill/Ruchill/Firhill) was the top postcode for referrals for both OOH and IH services. The North West was the most prolific referral locality for the IH service, accounting for half of all referrals.
- Referrals to the OOH service were likely to be a bit younger, with a more balanced gender profile. OOH referrals were more intense in terms of their profile: 17% were engaged with mental health services, they were more likely to have additional support needs and health issues and to flag a risk or concern. As a result, whilst IH had twice as many referrals as OOH, the total number of calls was similar (18,913 OOH, 18,781 IH), with an average of 10.9 calls per referral OOH and 5.7 for IH and the average duration of calls per referral was 87 minutes for OOH and 35 minutes for IH.

- The outcomes of calls for each service were similar, with a focus on offering advice and information, the individual feeling safe, managing through a short period of distress, improved access to resources and signposting to other services.
- Coping strategies and Mental Wellbeing were the top two outcomes logged for each service, with OOH logging twice as many Mental Health outcomes as IH.
- Referrals raised 1-15 issues, with an average of 3.8 per referral for OOH and 1.4 for IH. Anxiety/stress was the most commonly-featured issue for each service but suicidal ideation/behaviour was nearly as high for OOH.

Experiences of CDRS

Feedback from people using the service, referrers and other stakeholders on both OOH and IH CDRS was very positive.

Awareness: The service was perceived to be needed and to perform well. Awareness amongst IH referrers was very good, with 88% of all GPs/at least 94% of Glasgow City's practices having referred at least once by autumn 2022. Awareness of the OOH service was good amongst MHAU staff as key referrers but awareness amongst frontline Police Officers and Scottish Ambulance Service is likely to be much lower given referral rates as they are more likely to refer to MHAUs. The Co-ordinators of each service has worked hard to raise awareness, visiting referrers and building positive working relationships and this was further clarified during the first contact for referrals and in any feedback to referrers, if appropriate.

Referrals: The referral process was perceived to be quick (1 page), appropriate and sufficient. Referrals are made by phone, email or SCI Gateway. The Covid-19 pandemic had an impact on the service landscape, referral routes and methods of contact. Most contact has been by phone, although some face to face sessions have been facilitated if appropriate and a small number of in home outreach work has taken place in the IH service. Barriers to referral or service uptake include CDRS showing as No Caller ID or number withheld, the lack of self-referrals, people who have tried it not finding it for them not wishing to be re-referred, the fact that some potential referrers serve much larger areas and current referral routes adding more steps than necessary for people in distress, e.g. with Police taking them to MHAU for assessment rather than direct to CDRS.

Ratings: All stakeholders were asked to give CDRS 'marks out of 10' and achieved a mean score of 9+ for referrers and people engaging with the service and 8.3 for staff. Stakeholders were very complimentary about the quality of the service provided and felt staff were very good, very compassionate and provided an excellent listening service. Communications and partnership working were also rated highly.

Challenges: As with all new services, there are always some challenges which emerge. The complexity of cases and degree of distress was more acute than had been anticipated, particularly for the OOH service and the Covid-19 pandemic has impacted on the referral routes and service delivery. Making contact with people and scheduling calls have not always been easy or straightforward either. Each of the three CDRS services is funded separately and delivered by a discrete staff group, which has its pros and cons. Managing expectations and setting boundaries has been high on the agenda to ensure clarity of purpose as well as exiting people who have engaged once their support time is complete. The database has caused some frustration in terms of usability and the way in which data is gathered, which also influences how easy it is to report on it. None of the challenges dampened people's enthusiasm for the service, however.

Distinctive qualities: Not all stakeholders knew that CDRS was run by GAMH, a Third Sector organisation. However, this was not perceived to be a negative issue but more likely to be a positive, with strong knowledge and connections with community provision. CDRS was rated positively against others operating in this field and it was perceived to have a number of distinctive qualities. These included its speed of response, positive attitude towards referrals, the amount and frequency of contact provided to people in distress, the continuity of support from one or two personnel, the person-centred approach taken and the fact that use of alcohol or drugs is not a barrier to support.

Suggestions: The ratings and comments show strong support for CDRS as it is, but all stakeholders were asked if they had any suggestions for improvement. These include, in no particular order of importance: increasing face to face contact; the potential for self-referral; addressing the withheld number (which has been actioned); the ability for CDRS to refer onto other services to avoid the need for patients to return to GPs; 'holding' people until the service they have been referred to is available; more integrated pathways and service delivery (particularly with MHAUs and the new hubs); standardising access for different referrers; managing the relationship with DBI; increased support for CDRS staff; training referral agencies; maximising use of the website; introducing group work; providing more/longer support and extending opening hours (into the night and daytime at weekends) and age groups; refreshing the database to meet needs better; and improving equalities representation within the teams.

Sustainability: All stakeholders who gave their views would like to see CDRS provision continue and develop into a sustainable, integrated service in Glasgow.

Impacts: The impacts of the service on people using and referring to it were considered. People felt that it did make a positive difference to people as it was delivered in such a compassionate, non-judgemental manner. It made people feel better… heard, understood, safe, supported, cared for, 'normal' and motivated to improve their wellbeing. Some felt they may self-harmed or completed suicide were it not for CDRS. People had learned how to identify feelings and thoughts and some felt better equipped to cope in future – when in distress and/or when accessing other services - so there will be some longer term impacts. CDRS had also signposted people to other supports which had further impacts.

It gave improved peace of mind to referrers that people in distress will be supported and 'held', particularly when no other services were perceived to provide this kind of service to people in these circumstances. This made a referrer's job easier as they had something to offer patients either as a stand-alone service or whilst waiting for another specialist service.

Costs, savings & value: CDRS was perceived to save time for GPs and other primary care staff, as had been hoped. Time savings came in terms of reducing the length of the initial consultation when distress was evident and the referral was made (significantly for some, less for others) and in the subsequent length and frequency of consultations following referral as they knew the patient was in safe hands. Low, medium and high estimates of time saved based on average GP salary alone (not full cost) equate to £63k, £105k and £209k per annum. Lower Third Sector costs also compare favourably to suggest CDRS represents good value for money.

OOH referrers also felt their service and others will have saved time by referring to CDRS but this was harder for them to quantify.

Some people who have engaged with the service have claimed that it has saved their lives. It was not designed as a suicide prevention service but both IH and OOH services have worked with people who were actively suicidal. There is no way of knowing if they would have completed suicide or not and it is very difficult to put a cost on saving a human life but one estimate from the Department of Health, Social Services and Public Safety in Northern Ireland puts it at £1.7million.

The impacts for people assisted by CDRS have been both tangible – addressing problems with benefits, housing, debts, reconciling with families – and intangible, feeling better, more hopeful, more engaged in life, relationships and communities. A key support of CDRS has been supporting people to identify, normalise and deal with their thoughts and feelings. Sharing tools and techniques to cope when distressed, even if not universally adopted in future, helps to build resilience, lessens the likelihood of distress in future and the current/future load on a wide range of health and other services in addition to enriching the individual's life and those of families and friends. This is priceless.

CONCLUDING COMMENTS

This evaluation has tapped into the views of 70 stakeholders, reviewed project data and considered the context for the Compassionate Distress Response Service. The key take-aways from the evaluation are:

- The CDRS – both In Hours and Out of Hours – is perceived to be much-needed and wanted by people engaging with the service and referring agencies.
- It is seen to be providing an excellent level of care which is making a positive difference to both the people it supports and referrers, including time/cost savings.
- All stakeholders wish to see it continue and to develop to become a sustainable and embedded service supporting the people of Glasgow.
- Given the changing landscape, CDRS, funders and partners could consider a number of possible developments to build on success to date and improve sustainability, such as:
    - shifting to a more seamless service;
    - developing more integrated pathways and service delivery with MHAUs and Hubs;
    - direct referral into more mental health services by CDRS; and
    - walk-in support and/or self-referrals (even if just for those known to CDRS).

Contents

1 Introduction

1.1 This report

This report details the findings of the evaluation of the Compassionate Distress Response Service (CDRS) run by the Glasgow Association of Mental Health (GAMH), funded by Glasgow City Health and Social Care Partnership (GCHSCP). It was commissioned in late September 2021 and conducted by Clear as a Bell Research & Consultancy.

1.2 Background

1.2.1 What is it?

The Compassionate Distress Response Service aims to support people who are in psychological distress for a short period of time, by phone or face to face. They do this by compassionate listening, suggesting tools and techniques to help individuals deal with their distress and signposting or referring them to other services which can provide further assistance with their mental wellbeing and/or circumstances. It is operated by Glasgow Association for Mental Health and was commissioned by NHS Greater Glasgow and Clyde in January 2020. The service received its first out of hours (OOH) referrals on 25th May 2020, based at GAMH's office next to Glasgow Green. The service was extended to in hours (IH) referrals from 7th September 2020.

The **out of hours service** operates seven days a week, 5pm to 2am (63 hours a week) with phone or email referrals from Mental Health Assessment Units, Emergency Departments, Out of Hours CPNs and GPs, Scottish Ambulance Service and Police Scotland, Psychiatric Liaison, Mental Health Triage Car, British Transport Police and Social Work Standby. Referrals are responded to within one hour of referral. The service is designed to support people in distress who do not require medical intervention but who might otherwise utilise first responder and/or NHS resources, therefore providing a more appropriate support service for these individuals and freeing up first responders/NHS services. The service started with 2 Co-ordinators and 7 Distress Response Workers (DRWs), all working a 4 nights on/4 nights off pattern.

The **in hours service** operates Monday to Friday, 9am – 5pm (40 hours a week), with referrals made by phone or SCI Gateway. This service was designed to exclusively support General Practice, be that GPs directly or their colleagues such as Community Links Workers or Practice Nurses. Referrals are responded to on the same day or, if received later in the day, within 24 hours of referral. The service commenced with 1 Co-ordinator and 5 Distress Response Workers.

From September 2021, an enhanced pathway for 16 to 25 year olds has also been provided, funded by the Community Mental Health Supports & Services Framework, however this is not included within the remit of this evaluation.

CDRS staff members have been recruited with a variety of backgrounds to enrich the expertise – professional and life experience – which is brought to the development and delivery of the service. Many staff have psychology backgrounds, but homelessness, addictions, social work, benefits, teaching and mental health support are all represented.

1.2.2 What does it do?

The service, as its name would imply, offers a compassionate response to those experiencing significant distress, not a counselling or therapeutic service. The value and importance of listening to and really hearing people was highlighted throughout the initial research and validation sessions in the 2020 'Listen… Exploring Distress and Psychological Trauma'[1] study around distress and

[1] Listen... Exploring distress and psychological trauma. Final report September 2020 (scot.nhs.uk)

trauma. This clearly supported the decision to commission the service (originally driven by the Multi-agency Distress Collaborative, funded by Action 15 monies to support Scotland's Mental Health Strategy 2017-27) and the in-hours extension to the service, which was highlighted in GCHSCP's Primary Care Improvement Plan. Whilst people referred to the CDRS may not require medical intervention, they may still present with complex, multi-faceted issues.

The model of support is broadly the same for both out of hours and in hours services. Following referral, staff attempt to make contact with the distressed individual. In hours referrals are contacted at least three times and for out of hours referrals up to six attempts can be made to contact them. The first call checks in to see how the individual is and to explain the service to them. If the individual is no longer in distress or declines the service, no further contact is agreed. If the individual feels they wish to continue, initial support is provided and a plan agreed and/or the next contact time and date agreed. This will depend on how the individual is feeling and staff will adapt accordingly. For example, if the individual has just spent hours with first responders or with NHS staff they may need to rest so will just have a short discussion and agree to speak the following day. A key priority is safety, so if the person is feeling suicidal a safety plan will be agreed. There is a pathway to MHAU if assistance is required and CDRS staff will expedite things to Police if required to keep an individual safe. OOH cases have just a 1% escalation rate so saves clinical and Police time by supporting these people.

Staff aim to be clear on what the CDRS is and is not so that people who are referred can take a view on whether they wish to engage or not and to help manage expectations. For example, it is important to clarify that this is not counselling or therapy and that this is a short-term support service. That is not to say that significant progress cannot be achieved in that short period of time, however. CDRS staff take time to listen effectively to people throughout their engagement, and demonstrate empathy and compassion to the distress exhibited. A plan is then agreed with the individual, looking at their priorities for action and preferences so it is person-centred (and more likely to be followed). It is 'sticky care' so if CDRS say they are going to call at 5pm, they will call at 5pm because they know that person is going to be sitting waiting for them, and they keep calling if they are not.

CDRS staff provide relevant information about possible resources, self-help and self-care strategies and coping mechanisms, referring to ALISS, EPIC, online resources, YouTube and other appropriate apps. CDRS has researched and gathered useful resources and tools to assist people in distress but also look for new ones if these do not suit the individual or to try to tailor assistance to the individual's needs and/or interests. This includes having tools translated where appropriate. The CDRS teams use a strengths-based approach to promoting wellbeing, resilience and recovery so that people can identify and develop self-care and self-management skills to help them through their current period of distress and to help equip them for the future.

The CDRS provides support for up to a month or so to help people to be heard, to access information and tools to develop coping skills and/or signposting/referral into other services, including specialist support from organisations such as the Moira Anderson Foundation or longer-term support via GAMH's other services. Support from CDRS may be extended if cases are particularly complex and CDRS has been asked to 'hold' a few individuals until another service is available to support them appropriately, in order to keep them safe. The service had originally

expected to respond to low level distress, stress and anxiety but referrals have presented with a wide range of concerns, including complex personality disorders, self-harm and suicide ideation/behaviours, bereavement, addictions, relationship issues and isolation, for example.

1.2.3 The impact of launch timing

The CDRS was launched shortly after the Covid-19 pandemic, which had an impact on the service in several ways. It was an incredibly difficult time to establish a new service because of lockdown restrictions, but the out of hours team was up and running within a few months (they were commissioned end of January/early February 2020 and the service was launched in May 2020).

However, the team must have been very conscious of the increased need for the service as the pandemic and associated restrictions impacted on people in so many different ways: loss or illness of loved ones, the sudden change of having to stay at home (which may not have been a safe or nurturing space) for the majority of the day, isolation and loss of social contact, loss or change to employment, money worries, not to mention all the fears and concerns around catching Covid feeding existing anxieties and so on. Not to mention all the existing causes distress which prompted the service to be commissioned in the first place.

The service also had to evolve to respond to a rapidly changing landscape as new services such as the NHS24 Mental Health Hubs and the Mental Health Assessment Units which came on stream at around the same time and had a significant impact on proposed CDRS referral routes from first responders in particular.

Given the turmoil of 2020 and 2021 for services, Glasgow residents and the expansion of the service to in hours and the enhanced pathway for young people, the evaluation was commissioned to explore how the service was operating in practice and the difference it is making to individuals and referring agencies. It is hoped this will facilitate fine-tuning and help to embed the service more fully within the wider mental health support landscape.

1.3 Objectives

The overarching aim of this commission was to evaluate the Compassionate Distress Response Service, particularly to understand the impacts of the service on those who have received support and those who have made referrals by:

- profiling who uses the service;
- understanding the pathway for accessing the service;
- articulating the input provided by CDRS;
- understanding the outcomes and impacts for people using the service and referrers; and
- describing the cost of the service as it relates to the outcomes for people.

1.4 This report

The next section of this report outlines the approach taken to the independent evaluation, the primary and secondary research undertaken and provides a profile of participants for information. The report goes on to set the context, explore the data held by the service and feedback from stakeholders. Impacts follow, and the report closes with concluding comments for consideration.

2 Method

2.1 Introduction

The evaluation of the Compassionate Distress Response Service (Out of Hours and In-Hours only) was commissioned in autumn 2021. A project plan was developed following the inception meeting and in-depth discussions with the senior CDRS team and preliminary consideration of the database. The plan considered the objectives and how each of these would be met via the different elements of the fieldwork, how best to involve the key stakeholders and draft topic guides for discussions with each stakeholder group (Co-ordinators, staff, referrers/stakeholders and people referred to the service).

The evaluation involved three principal elements:

1. a brief literature review to set the context for the service;
2. a review of existing data held by CDRS; and
3. primary research with CDRS staff members, people who had used the service, those who had referred to the service and other relevant stakeholders.

2.2 Setting the context

A brief literature review was conducted to provide context for the Compassionate Distress Response Service, locally and nationally. This sought to outline the background to the development of the service and its key influences, plus also highlight any additional relevant local or national literature since the "Listen..." report on distress and trauma was published two years ago. This involved searching academic databases and wider internet searches. The context is outlined in section 3 of this report.

2.3 Reviewing existing data

The CDRS, as would be expected, records all referrals on a database. This logs details of the referrer, the person referred, the contacts made (attempted and successful), issues raised, support provided and outcomes achieved. The database contains a mix of quantitative and qualitative data and this was reviewed by Clear as a Bell to help describe the profile of referrals, the support provided to them by the CDRS team and, most importantly, the impacts of the service on people experiencing distress. The data is outlined in section 4 of this report.

2.4 Primary research

A significant amount of effort went into securing the views of relevant stakeholders during the primary research phase of the evaluation, reflecting both the out of hours and in hours services. Given lockdown restrictions with the rise of Covid and its impacts on stakeholders throughout the evaluation period, stakeholders were invited to give their views in a way and at a time that suited them. This involved a mix of individual and group face to face discussions, telephone interviews, Teams/Zoom discussions and email dialogue.

The CDRS team facilitated contact with staff, people who had used the service and referrers to both services. GCHSCP commissioning staff raised awareness of the evaluation and sought support for contact with GPs at Clinical Director level. Clear as a Bell was invited to appropriate Teams meetings at city and locality level to gather views and discuss how best to gather GP views. HSCP staff also invited GPs to give their views via email with a recruiting survey, issued more than once - inviting all GPs initially and then encouraging GPs who had not used the CDRS to participate in the evaluation. Clear as a Bell then phoned and/or emailed the contacts provided to set up interviews.

Despite much effort, Clear as a Bell was unable to complete any interviews with GPs who had NOT referred to CDRS. It had been hoped that some non-referrers would be interviewed to explore any issues or barriers to referral of which the service was unaware. However, at the time of writing 88% of Glasgow's GPs were reported to have referred to the in hours service which is an extremely high referral rate and may itself suggest a lack of barriers.

People who had used the service were first contacted by CDRS team members to establish if they were comfortable and stable enough to give their views and provided with an information sheet about the research. This outlined the purpose of the evaluation, who was being invited to participate, what would be required and stressed the importance of their wellbeing and consent/ability to withdraw at any point, etc. People who had used the service and gave their views also received a 'thank you' of a £20 supermarket voucher for their participation, although one person preferred a donation to be made to a food bank instead.

The final tally of primary research discussions was **70 individuals** giving their views, as follows:

- 14 CDRS staff members – 3 individual interviews with Manager and Co-ordinators and three group discussions with team members (2 x OOH, 1 x IH)
- 9 people who have used the service – 5 IH, 4 OOH
- 11 OOH referrers – including NHS Mental Health Assessment Unit (5), Police Scotland (2), Scottish Ambulance Service (2), Emergency Department Consultant (1) and Psychological Liaison (1)
- 31 IH referrers – including GPs/CQLs/CDs (25, individually and in groups), Community Links Workers (4) and Mental Health nurses (2)
- 5 other relevant stakeholders, to gain a strategic perspective

2.5 Issues to consider

No research is perfect and this must be acknowledged. For example, despite best efforts, no GPs who had not referred to CDRS were interviewed and this should be taken into account. The format/presentation of some of the data held by CDRS, or at least the way in which it was provided to the researcher, also makes it challenging to analyse easily at present.

Because of the nature of the service, the number of discussions with people who have used the service is low (9) and they were selected by the CDRS team rather than a random sample. Safety was the number one priority and individuals who had used the service were contacted by CDRS to establish if they were in a relatively stable place from which to be able comment on their experience (focussing on the service, not the issues which brought them to CDRS to minimise risk of them being triggered). It is only to be expected that some people may not wish to participate in research on any project, but particularly on something which might remind them of a difficult time in their lives. The fragility of people's mental wellbeing was also clear as, whilst some were in a good place when they gave permission to be contacted, this had declined by the time of interview despite contact being attempted as soon as contact details were provided. The researcher therefore proceeded with caution and took a participant-centred approach.

3 Context

3.1 Introduction

Time was spent particularly at the start of the evaluation to search for relevant literature to help set the context for the Compassionate Distress Response Service: where it had emerged from, where it sat in relation to other services and to help inform where it might go next. The literature search was a relatively 'light touch' element of the evaluation, as the main purpose was to evaluate how the service was delivering in practice according to its various stakeholders.

Literature online and within academic databases was explored to help illuminate the evaluation, although much of that within academic databases in particular tended to be of interest and helpful to inform the researcher but of less direct relevance to report here.

This section considers the national context, including other projects to note, and the Glasgow context.

3.2 National context

3.2.1 Introduction

Clinical mental health services are themselves widely seen to be facing challenges across Scotland, with long waiting lists, a disconnected and fragmented system, recruitment issues and a focus on crisis and mental ill health rather than prevention and promotion of good mental health. There has been a recognition at national and local levels that change is required, with a shift to a less clinical and more collaborative approach to supporting people's mental health and wellbeing with greater preventative and early intervention focus, in addition to a more person-centred or holistic approach.

The prevailing narrative has also identified the need for mental health to be more embedded within policies and practice and for the need for social, environmental, economic and cultural factors which can contribute to or exacerbate poor mental health to be addressed. These points are covered to different degrees and in different ways in the various strategies, action plans and pilot projects at national and local levels.

3.2.2 The Mental Health Strategy

The Mental Health Strategy for Scotland 2017-2027[2] asserts the need to prevent and treat mental health issues as much as physical health problems, working to improve 4 key areas:

- prevention and early intervention;
- access to treatment and joined up accessible services;
- the physical wellbeing of people with mental health issues; and
- rights, information use and planning.

The strategy was published in 2017 – i.e. before the Covid-19 pandemic - and made a number of commitments. For example, to help increase access to treatment an investment of £35 million for 800 additional mental health workers so that dedicated mental health support would be available in all A&Es, GP surgeries, prisons and police station custody suites. Improving support for preventative services to tackle issues earlier, including reviewing the role of school counselling services and CAMHS was also included.

[2] Mental Health Strategy 2017-2027 - gov.scot (www.gov.scot)

A rights-based approach targeting people who need support most was also highlighted in addition to a focus on maintaining/improving the mental health of children and young people. Specific mention was made of the DBI evaluation and implementation of its findings, plus development of national unscheduled mental health services to complement local services and address waiting times.

The 'Together Let's Care for your Mental Health'[3] campaign was also developed by NHS24, Police Scotland and the Scottish Ambulance Service as a result of the Mental Health Strategy.

The third annual progress report on the Mental Health Strategy in March 2021[4] highlights the significant impacts of the Covid-19 pandemic on people's mental health, the inequality of impacts on people and the impacts on both service delivery and delivery of the strategy. However, it asserts the vision of the Mental Health Transition & Recovery Plan (published in October 2020) to be "a Scotland where people can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma".

The progress report outlined a streamlined approach to delivering on actions set out within the original Mental Health Strategy, prioritising 5 actions which included Distress Brief Interventions and the recruitment of 800 additional mental health workers (61% complete by July 2020[5]). The Mental Health Transition and Recovery Plan contains 107 actions, including all of the outstanding actions of the Mental Health Strategy which were paused because of the pandemic and 12 key commitments which are being taken forward quickly.

In February 2021 a Mental Health Recovery and Renewal Fund was established with an investment of £120 million. This includes £10 million to clear Psychological Therapy waiting lists and enhanced support for primary care/community support.

The Mental Health Strategy was always meant to be reviewed at its midpoint and the impacts of the pandemic reinforced the need for this to be done. There is currently a consultation[6] underway to help refine the content of a new Mental Health and Wellbeing Strategy for Scotland for 2022-2027, including whether the four key areas of focus outlined in the Mental Health Transition and Recovery Plan are still the right ones to focus upon. This included "providing a rapid and easily accessible response to those in distress". The consultation highlights the need to address the underlying reasons behind poor mental health as well as helping to create the conditions for people to thrive, challenging the stigma around mental health and providing specialist help and support for mental illness.

3.2.3 Suicide Prevention Strategy

Whilst CDRS is not designed to be a suicide prevention service, the data shows that it deals with a large number of people who are or have recently engaged in suicidal behaviour or ideation or self-harm. Bereavement – by suicide or other means – is also a significant issue for people using CDRS. It is therefore relevant to consider the national context for this to some degree.

The ten year Creating Hope Together: Scotland's Suicide Prevention Strategy 2022-2032[7] and associated three year Action Plan[8] have recently been out to consultation, revised and published in September 2022. The strategy and action plan have embedded throughout the principles of Time, Space, Compassion[9], the recommendations for improving the response to suicidal crisis, produced by the National Suicide Prevention Leadership Group with insight from people with lived experience amongst a wide range of other relevant stakeholders. This creates the conditions for

[3] Together, let's care for your mental health | NHS inform
[4] Mental health strategy: third annual progress report - gov.scot (www.gov.scot)
[5] Annex A: Update on the Progress of Continuing Mental Health Strategy Actions - Mental health strategy: third annual progress report - gov.scot (www.gov.scot)
[6] Mental health and wellbeing strategy: consultation - gov.scot (www.gov.scot)
[7] Creating Hope Together: Scotland's Suicide Prevention Strategy 2022-2032 (www.gov.scot)
[8] creating-hope-together-scotlands-suicide-prevention-action-plan-2022-2025.pdf (www.gov.scot)
[9] Time, Space, Compassion Three: simple words, one big difference : Recommendations for improvements in suicidal crisis - Response (www.gov.scot)

people who are feeling suicidal to understand their feelings and feel safe in expressing those feelings to others, knowing they will receive compassionate, timely response, and the support they need. This includes safety planning and the development of self-management techniques, all of which are core to the CDRS approach.

The strategy and action plan also promote the need for improved suicide awareness, stigma reduction and prevention work, including testing new services for those in crisis and following a bereavement. The need for co-ordinated, collaborative and integrated approaches are also highlighted, where everyone (in Government, services and wider society) takes responsibility for actions to reduce the incidence of suicide, address its root causes (including poverty, environmental and social factors) and support those affected by it, with a focus on recovery.

3.2.4 NHS24 Mental Health Hubs

NHS24 Mental Health Hubs were established in 2019 as part of the 111 service to help address the scale of mental health distress, including attempting to reduce the number of people presenting to A&E with mental distress and mental health issues. The hubs are staffed by Psychological Wellbeing Practitioners (PWP)[10], Mental Health Nurses and Mental Health Senior Charge Nurses who work as a team to support patients who require urgent mental health support. The clinical staff provide a triage assessment and work to ensure patient safety and appropriate clinical support for those in crisis. Where there is not a clinical need, the PWPs provide compassionate support to those experiencing distress and refer patients to appropriate local support services, such as DBIs, where required.

3.2.5 Mental Health and Wellbeing in Primary Care Service Model

The Mental Health in Primary Care Short-Life Working Group Report[11] 2022 and associated guidance[12] published in January 2022 support the establishment of the Mental Health and Wellbeing in Primary Care (MHWPC) Service Model within localities with a group of GP practices to provide assessment, advice and support for people who require a mental health or wellbeing response. The service model effectively constitutes a 'hub' where a multi-agency team can provide a joined up service in a person-centred way. The team could involve Mental Health Nurses, Psychologists, Enhanced Practitioners, Community Link Workers, Occupational Therapists, Addictions Workers, Financial Inclusion Workers, Exercise Coaches, Family Support Workers and Peer Networks, for example, to provide local support but also connect to specialist services based elsewhere as appropriate.

The guidance outlines the process to be followed, with a view to these MHWPCs being established across Scotland by 2026. These are viewed to be beneficial for individuals and practitioners, connecting people to the right, joined up support more quickly (in terms of both actual time to be supported but also by taking a more preventative/early intervention approach rather than waiting until crisis point), in a trusted local space.

The Short Life Working Group[13] recommended recognition of the central roles primary care and mental health and wellbeing have within each other's services and the need for primary care mental health to deliver a 24/7 service. The need to review Action 15 of the Mental Health Strategy or Primary Care Improvement Fund (PCIP) funded developments alongside any new service development plans was also highlighted.

[10] Our staff | NHS 24
[11] Annex A - Mental Health in Primary Care Short Life Working Group - Short Life Working Group for Mental Health in Primary Care: report - gov.scot (www.gov.scot)
[12] Mental Health in Primary Care Planning Guidance for Mental Health and Wellbeing in Primary Care Services (www.gov.scot)
[13] Annex A - Mental Health in Primary Care Short Life Working Group - Short Life Working Group for Mental Health in Primary Care: report - gov.scot (www.gov.scot)

The Scottish Government released a paper[14] in January 2022 outlining primary care mental health models to inform the Mental Health in Primary Care Short Life Working Group recommendations. The paper included details on the CDRS approach alongside previous Glasgow pilots Govan SHIP and the Jigsaw Project and a variety of other options such as ADAPT (Accessible Depressions & Anxiety Psychological Therapies) in Grampian and Lanarkshire, the Craigmillar Medical Group's Mental Health Model in Edinburgh and Patient Assessment & Liaison Mental Health Service (PALMS) in Tayside.

3.2.6 National Distress Brief Intervention Pilot and roll out

The Scottish Government funded a five year pilot Distress Brief Intervention (DBI) in 2016[15]. The DBI sprang from Suicide Prevention and the Mental Health Strategies and was developed with direct engagement with people who had experienced distress, front-line service and a literature review. There were four initial pilot areas (Aberdeen, Inverness, Lanarkshire and Scottish Borders[16]) following a competitive bid process. The DBI defined distress as "An emotional pain for which the person sought, or was referred for, help and which does not require (further) emergency service response (NHS Scotland 2017)".

The DBI operates at two levels. Level 1 involves a trained member of frontline staff (for example from primary care, Police Scotland, Scottish Ambulance Service, NHS Emergency Departments, NHS24 and the Third Sector) giving a quick compassionate response to a person in distress, with the offer of a referral for further support. Level 2 support is provided by trained Third Sector staff (pilot areas are delivered by Penumbra in Aberdeen, Scottish Association for Mental Health in the Scottish Borders, Support in Mind Scotland in Inverness, Richmond Fellowship/Lanarkshire Association for Mental Health in South Lanarkshire and Lifelink in North Lanarkshire) who aim to make contact within 24 hours and provide emotional and practical support for up to 14 days (although this could be extended if appropriate). This support can be provided by phone calls, texts or in person and interventions are logged in a Distress Management Action Plan (D-MaP). The DBI service was initially for those aged 18+ only but this was extended to include 16 and 17 year olds in 2019. The majority of Level 2 support is provided during a standard working day Monday to Friday, 9am-5pm.

In 2020[17], the Scottish Government made a commitment to expand the DBI approach to provide national coverage for people presenting in distress to the NHS24 Mental Health Hub, embedded within every NHS board area, by 2024. Funding of more than £1 million was provided and the DBI pilot was extended to facilitate that transition via an associate programme. This was in addition to £3.8 million to increase capacity of telephone and digital mental health services (£2.6 million to expand NHS24 Mental Health Hub and Breathing Space telephone and web support plus £1.2 million to provide addition Computerised Cognitive Behavioural Therapy). DBI has been established in Glasgow (as part of the NHS24 contract) and Inverclyde by SAMH and Penumbra expanded its work in Aberdeen to Moray in 2019[18] and it is believed a Tayside service was recruited in late 2021 and a new Edinburgh service is being recruited at present. Support in Mind Scotland has also expanded its DBI work in the Highlands[19] (covering NHS Highland and NHS Western Isles) to now offer a service in Argyll & Bute and Dumfries & Galloway, supporting 4 NHS board areas. There may be other associate DBIs in the planning stages.

As a national pilot, evaluation was built in at the start of the programme and the final evaluation was recently published. Some of the key findings were as follows:

1. The DBI was considered to be a success, with mostly appropriate referrals and adaptations to localities whilst still retaining core elements of the DBI programme.

[14] Primary care mental health models in Scotland - gov.scot (www.gov.scot)
[15] Distress Brief Intervention - Background | DBI.scot
[16] Glasgow City HSCP was also awarded funding but decided to pursue an alternative distress response, following the work of the Multiagency Distress Collaborative.
[17] New mental health support - gov.scot (www.gov.scot)
[18] Penumbra to lead Distress Brief Intervention in Moray - Penumbra
[19] Distress Brief Intervention (DBI) | Support in Mind Scotland

2. Two out of five referrals (41%) were made by primary care in-hours, 25% by A&E, 16% by Police Scotland and 10% by psychiatric liaison. Just 4% were from Scottish Ambulance Service, 2% from mental health unscheduled care and out of hours services and 2% from out of hours primary care. Women were more likely to be referred by primary care (46% v 34%) and men by A&E (30% v 21%).

3. Referrals from primary care and mental health unscheduled care teams were more likely to take up support from Level 2 than those referred by A&E, Police Scotland or the Scottish Ambulance Service. This may be because of the situation people were in at the time and/or they were less clear on what the DBI was or could do for them. Leaving written information on this helped Level 2 engagement.

4. In some cases the DBI process generated an additional task for Level 1 referrers, for example Police officers had to enter the person's details onto the Vulnerable Persons Database if they made a DBI referral, even if they would not have done so otherwise and did not consider them to be a vulnerable person.

5. Successful contact was made within 24 hours of referral in 65% of cases (lower at 60% in Lanarkshire) and 21% at a later date, whilst 14% could not be contacted.

6. Whilst most people found the D-MaP to be a useful approach to work through triggers and coping mechanisms, some Level 2 practitioners felt it was "an overly manualised approach" which did not allow trust to be built and the individual to talk about their distress without a lot of paperwork, and people using the service had also reported there was too much paperwork.

7. 58% of referrals were female and 42% male, with 4 logged as 'other gender'. Two-thirds of referrals were aged 16-44 (68%), with women more likely to be aged 16-24 (25%) and men aged 25-34 (28%). Nearly 60% lived in the 0-40% most deprived SIMD areas and 98% were white, although only half provided their ethnicity.

8. As might be expected, individuals often presented with more than one issue or contributing factor. Feeling depressed/low mood was the most common presenting problem (61%) for both genders, but stress/anxiety was more of an issue for women (61%) than men (45%) and men were more likely to present with suicidal thoughts (39% v 28%) and suicidal behaviour (10% v 7%).

9. Relationship issues were the most frequently cited contributory factor for both men and women (48%), followed by alcohol use (22%; higher for men, 29%, than women, 16%), life coping issues (21%), money worries and unemployment (both 18%). Substance misuse was a contributory factor for 19% of men and 7% of women. Both alcohol and substance misuse were higher for referrals from A&E (35% and 23%) than primary care (10% and 5%).

10. 29% were signposted to statutory services and 73% to non-statutory services from Level 2 DBI services and 11% were provided with a supported connection to statutory services and 25% a supported connection to non-statutory services.

11. The DBI Level 1 response had immediate benefits for individuals, with most reporting that the Level 1 responder had helped them cope with their immediate distress (mean rating of 7.8 out of 10), although younger people, those with higher levels of distress and those presenting at A&E gave lower ratings of compassion. 9 out of 10 individuals showed a decrease in distress by the end of the Level 2 intervention, although it was higher for 1 in 10. 1 in 10 also revealed they may have attempted suicide or continued suicidal thoughts if DBI had not been offered.

12. Women had slightly (but statistically significant) higher distress levels at the end of DBI than men, taking into account their starting point, so DBI Level 2 may not be working as

well for women as men although it is unclear why this is the case. Conversely, younger people (aged under 35) had lower distress levels than older adults, most likely because DBI practitioners helped them to understand why they were distressed which helped reduce distress levels. Building on helping individuals to understand why they became distressed and how to recognise it starting was recommended as a key means of reducing/addressing distress in future.

13. Those who received support at Level 2 had on average 4.1 support sessions.

14. 84% of those who were supported achieved a planned exit, whilst 16% stopped attending/responding to contact. Lanarkshire had lower engagement: 76% took any support, 62% any Level 2 support and 49% were supported to a planned exit.

15. Whilst 30% of individuals giving their views in the evaluation though 14 days' support was not enough, the length and intensity of support were not found to be associated with individual outcomes. The guideline of 14 days' support was met by 58% of people who took up support (more than just the initial call). 27% of all referrals received over 14 days support, 44% of those who took up Level 2 support.

16. 47% of respondents to the follow-up survey had contacted their GP, Police, Ambulance or A&E because they were in distress within three months of their last contact with DBI, but there is no way of knowing if this is an improvement on previous behaviour or not.

17. The role of DBI Central and the programme manager – co-ordinating, networking, information sharing, problem solving and championing - were seen to be essential components of its success, as were DBI Gatherings[20] and local implementation groups.

18. Challenges to implementation included local services doubting the added value of DBI, some Level 1 practitioners feeling mental health issues were outwith their role and some frontline service systems not incorporating DBI referrals easily.

19. Level 1 and Level 2 practitioners felt DBI was an effective way to respond to distress and the DBI has improved integrated working across frontline services.

The evaluation therefore supported DBI, and its continued national roll out, as an effective response which helped most (but not all) people in distress to manage and reduce their distress in the short term and longer term for some individuals. It was also suggested that consideration be given to DBI providing follow-up support or a more tapered withdrawal, particularly while waiting for a specialist service as this can be a difficult time. Further research was also recommended around the level of uptake of specialist services after Level 2, the longer-term impact of DBI on individuals and wider services, whether/how DBI might help prevent suicide and why some individuals experienced increased distress over the course of the DBI intervention.

The evaluation noted the potential impact on local services because of DBI roll out, in terms of both waiting lists and sensitivities around existing services perceiving DBI to be a threat rather than complementary providers. Positive engagement was therefore perceived to be required to overcome both issues.

The Distress Brief Intervention approach has recently (August 2022) been adopted in Derwentside, the first pilot of the approach in England which is led by Mental Health Concern and Tees, Esk and Wear Valleys NHS Foundation Trust[21].

In June 2022 it was announced that the Scottish Centre for Social Research (ScotCen)[22] will lead the DBI Impact Evaluation on Suicide and Self-harm (DIMES) project, which will evaluate the impact of DBI on suicidal ideation, behaviour and self-harm. A key aim of the evaluation is to

[20] DBI Gatherings are held every six months for partners to share learning and experiences.
[21] England's first Distress Brief Intervention service - Mental Health Concern
[22] NatCen Social Research (scotcen.org.uk)

gauge the impact the DBI approach has on reducing suicidal ideation, behaviour and self-harm in the short and longer term for those presenting with distress. This picks up on positive comments in respect of suicidal ideation, behaviour and self-harm made by people supported by DBI during its recent evaluation and a recommendation by the evaluation for further research around whether and how DBI might help prevent suicide. This project is funded by the National Institute for Health and Care Research and ScotCen will be supported by the universities of Glasgow, Stirling, Edinburgh and Glasgow Caledonian plus an advisory group of people with lived experience of accessing support whilst in distress.

Suicidal ideation, behaviour and self-harm were significant issues for people accessing support from CDRS so the DIMES findings should be of interest.

3.3 The Glasgow context

3.3.1 Strategies

National strategies and direction from the Scottish Government are reflected in local strategies and plans. The Primary Care Improvement Plan (PCIP) and associated funding was reviewed in April 2022[23] to inform development and spending for the next three financial years. The latest plan (draft) and the preceding one prioritised Mental Wellbeing, which has only been exacerbated since the pandemic and is a significant issue for general practice. Progress has included: extending the Community Link Worker programme and Lifelink service provision; and developing the Compassionate Distress Response Service (In Hours).

Mental Health and Wellbeing in Primary Care Services (or 'Wellbeing Hubs') aim to improve access to mental health and wellbeing support for people in Glasgow. During 2022-2023, the HSCP will develop 'starter site' Hubs in Govanhill/East Pollokshields, Springburn, and Dumbarton Road Corridor, with the service commencing 2023. Initially the Hubs will support adults (16 years+) who are registered with the 23 practices and seeking support with their mental health and wellbeing (including stress and/or distress).

3.3.2 Development of the CDRS approach

The Compassionate Distress Response Service is an alternative distress response pathway, which was a specific work stream of the NHS Greater Glasgow and Clyde Multiagency Distress Collaborative (MDC)[24], reporting in 2019. The MDC was a three year programme funded by the Scottish Government Mental Health Innovation Fund and based on the Institute for Health Care Improvement Collaborative Model. In addition to the Alternative Distress Response pathway, the Collaborative identified work streams around repeat presentations to Emergency Departments by people known to Community Mental Health Teams, training, staff support and community engagement.

One of the key outputs of the Collaborative was the Distress Response Framework, which outlined different levels of distress, where people in distress might seek help and the type of response they might expect. This shaped the ensuing work around an alternative, non-clinical response to distress which would provide immediate compassionate care and support to someone in distress, to reduce their distress and help them to stay well.

Throughout their discussions, the Collaborative agreed the following definition of distress:

> *"Distress is an emotional state, not an illness which is expressed and comes to our attention when a person's internal capacities and external supports cannot contain something."*
> *(Multiagency Distress Collaborative Expert Reference Group July 2016)*

[23] Primary Care Improvement Plan - 2022/3 to 2025/6 (hscp.scot)
[24] NHS Greater Glasgow and Clyde Multiagency Distress Collaborative.pdf (scot.nhs.uk)

The Collaborative distilled the four key elements of a compassionate response identified by the University of Birmingham (meaningful connection, patient expectations, caring attributes and capable practitioners) to three key principles, which guide and are on display in the CDRS:

1. We Care
2. We Listen
3. We Support

The CDRS approach was developed by GAMH but informed by a range of other services and literature, such as the Renfrewshire Association for Mental Health (RAMH[25]) First Crisis Service and the Safe Haven Cafes in Aldershot.

RAMH's First Crisis[26] is largely a telephone based crisis service which provides short-term support to anyone aged 16 plus in Renfrewshire who is experiencing a crisis in their mental health. Some face to face appointments or outreach support are also provided if appropriate. The service takes a strengths-based, recovery-oriented approach which helps people who access the service to develop or grow effective self-management strategies.

The service is provided 365 days a year, 9am-8pm Monday to Friday and 9am-5pm Saturday and Sunday. It was interesting to note that the First Crisis Freephone number is publicised on their website, alongside a standard rate landline number, as CDRS do not share their telephone number or allow self-referrals. RAMH provided pro bono consultancy support whilst GAMH was establishing the CDRS.

The Aldershot Safe Haven café is an out of hours, drop-in service staffed by NHS and Third Sector teams, which has been operating since 2014. It has been extended to other localities in Hampshire and emulated elsewhere. The service is geographically central and easily accessible by public transport to facilitate easy access for all. It provides an out of hours service 365 days a year and aims to support people in or nearing crisis by compassionate listening support and signposting to appropriate services. This aims to help support people to maintain positive mental health and has been shown to reduce their use of NHS services such as Emergency Departments and also Police contact. The Safe Haven approach has evaluated positively with service delivery partners and individuals who have used the service.

3.3.3 Other services based in Glasgow to note

Mental Health Assessment Units

Two Mental Health Assessment Units (MHAUs) were established – at Stobhill and Leverndale Hospitals - around the same time as CDRS, when the Covid-19 pandemic kicked in. These were designed to minimise attendance at NHS Emergency Departments by patients with mental and not physical health issues. The MHAUs were found to reduce waiting times and provide a more appropriate response, from specialist mental health staff.

Whilst the initial MHAU service was helpful in the short term to respond to the need during the pandemic, this was considered to be an unsustainable way to deliver the service in the longer term[27]. The benefits of the MHAU approach for people in crisis, staff and partners were clear and this also responded to Scottish Government expectations around unscheduled care and mental health assessment, so a revised approach and associated pathways were approved in 2021, embedding the MHAU service within NHS Greater Glasgow and Clyde.

The MHAUs are effectively a one stop shop for NHS24, Police Scotland, Scottish Ambulance Service (with whom they operate a mental health paramedic car service), Emergency Departments and Primary Care to refer people in crisis or distress. Patients will have a full assessment of their mental health and wellbeing then be referred on in a 'stepped care model' to specialist mental

[25] Please note that RAMH has been renamed Recovery Across Mental Health
[26] RAMH | Recovery Across Mental Health
[27] IJB Report (hscp.scot)

health services if appropriate, CDRS or be discharged. MHAUs operate 24/7, 365 days of the year and provide face to face, telephone and e-health services.

Primary Care referral routes

In addition to referral pathways to MHAUs via Consultant Connect, Primary Care can also refer patients directly to Community Mental Health Teams (CMHTs) and Primary Care Mental Health Teams (PCMHTs) as well as other providers like Lifelink and the Compassionate Distress Response Service.

NHS24 Mental Health Hubs

The NHS24 Mental Health Hub provides a 24/7 call service via the 111 number for anyone, of any age, experiencing mental distress, symptoms or with queries about medication. As mentioned earlier, this is a national service but it is worth mentioning that in Glasgow, the Hubs can refer callers to the MHAUs or the Glasgow DBI, run by Scottish Association for Mental Health (which also operates a DBI service in other areas, as previously mentioned). Some of the referrals to MHAUs from the hubs may then be referred to CDRS. These hubs were also introduced just before the Covid-19 pandemic/CDRS was commissioned.

Breathing Space

Breathing Space received additional funding nationally as part of the pandemic response and is open to people in Glasgow. It provides a freephone telephone listening service[28] in the evenings (6pm to 2am) Monday to Thursday and throughout the weekend (6pm Friday to 6am Monday). Their advisors provide an active listening service to anyone in Scotland with empathy and understanding, and also provide information and signposting to other services. Breathing Space also provides an online chat service via the website breathingspace.scot, 6pm-2am Monday to Friday and 4pm-12am Saturday and Sunday. The website highlights the Living Life[29] Scotland-wide telephone cognitive behavioural therapy (CBT) service for those aged 16 plus experiencing low mood, anxiety or depression. The service operates Monday to Friday 1pm-9pm and provides an appointment based service over 4-6 sessions. Living Life is managed and delivered by NHS24.

The Samaritans

The Samaritans[30] also provide a volunteer-led 24/7, 365 free telephone listening service for those in crisis and distress, with a particular focus on reducing the number of lives lost to suicide and promoting mental and emotional wellbeing. People can also contact Samaritans via email, text, letter and by visiting their local branch, although the vast majority of contacts are by phone (at least in 2017, as reported on their website[31]: 42,000 calls; 6,800 texts; 2,400 emails and 400 face to face contacts). The Glasgow branch is based in West George Street and is open 7 days, 9am – 10pm.

3.4 Other projects of interest

The previous research study around distress 'Listen… Exploring Distress and Psychological Trauma'[32] highlighted a number of different approaches which were relevant to the development of the Compassionate Distress Response Service. These are not repeated here, but any new work in the intervening two years was sought for information.

3.4.1 Compassionate Care Call Project

The link between compassionate support following self-harm presentation at A&E has also been explored by Sussex NHS Foundation Trust. The Trust introduced a pilot Compassionate Care Call Project[33] in October 2020 for 12 months, which was extended until April 2022 pending further

[28] Breathing Space is a free confidential service for people in Scotland. Open up when you're feeling down - phone 0800 83 85 87
[29] Living Life (breathingspace.scot)
[30] About Samaritans Scotland | Samaritans Scotland
[31] Samaritans of Glasgow
[32] Listen... Exploring distress and psychological trauma. Final report September 2020 (scot.nhs.uk)
[33] AE project final evaluation report FINAL 011121 (2).pdf (nice.org.uk)

funding. This pilot recognised that nearly half (43%) of the people who die by suicide in the UK have attended an Emergency Department in the year before their death. It aimed to improve the support provided to people following an episode of self-harm/distress in order to reduce further self-harm or completed suicide and A&E re-admissions by being compassionate and revisiting/actioning safety planning with the individual.

This service consisted of three Mental Health Support Workers who called patients presenting to A&E with self-harm (and referred to the service by the A&E Mental Health liaison team) within three working days. Patients were given an appointment card when referred by clinical staff which detailed when they would be called, outlined why they would be called (checking their safety, supporting them with their care/safety plan, identifying services that might support them and giving them time for a calm, compassionate conversation), what to expect logistically (withheld number, 20 minute call, possible text to confirm availability or follow up), what the call would cover (safety plan, steps to aid recovery, what might keep them safe and support network), space for the individual to make notes about treatment or onward referral and information on further sources of support. The MH Support Workers supported the outcomes of the A&E psychosocial assessment by supporting their care plan and signposting to appropriate services.

A total of 1,827 referrals were made in 15 months from seven A&Es across Sussex, with more female referrals than male. 80-95% of referrals had contact made and 76% kept the next appointment with services after their compassionate call. Although the evaluation cited no direct evidence of the calls reducing self-harm or suicide it was deemed likely that they contributed to this via continuity of service and compassionate recognition of people's experiences. The evaluation also notes that in 2.4% of cases MHSWs initiated actions to support the individual's safety. The evaluation concluded that the intervention was successful and should continue, building on the holistic focus on individuals, team support and good connections built with the social care and charitable sector as well as mental health organisations, to become a sustainable and embedded part of the service provided.

3.4.2 Community Wellbeing Centre

Other parts of Scotland are also pursuing local solutions to a compassionate distress response. For example, Dundee is developing a Community Wellbeing Centre, which will be a centrally based, Third Sector run centre open 24/7 where people in distress can receive immediate, compassionate support. It is anticipated that the Penumbra-run DBI will be based in the new centre[34]. The aim is for the centre to take a person-centred, co-ordinated approach to link people in distress to services and supports which may assist them, including distress brief intervention, carer support and immediate specialist mental health assessment if appropriate. The centre will be open to anyone who considers themselves to need support. The centre will have strong community links and work with existing mental health and wellbeing services run by both statutory and Third sector services. During the initial phase, stakeholder engagement has been run by Dundee Volunteer & Voluntary Action[35] to inform the development of the centre. Stakeholder groups focus on four distinct areas: Building/Aesthetics; Procurement, Communication and Engagement; and Pathways, Connections and Technology. Plans for the centre commenced in April 2021 and it is expected to open in late 2022.

3.4.3 Clydebank Distress Service pilot

Clydebank also initiated a 5 month pilot Distress service in March 2022 for anyone aged 16+ in West Dunbartonshire experiencing distress but not requiring clinical or specialist support. The service, run by Stepping Stones, aims to provide a compassionate response with one to one support, brief interventions, assessment of needs and follow-up support. Walk in referrals are also received on Thursdays 2-6pm, with prior telephone call.

[34] MENTAL HEALTH CRISIS SUPPORT IN DUNDEE | Dundee Health and Social Care Partnership (dundeehscp.com)
[35] Community Wellbeing Centre - Dundee Volunteer & Voluntary Action (dvva.scot)

4 The numbers

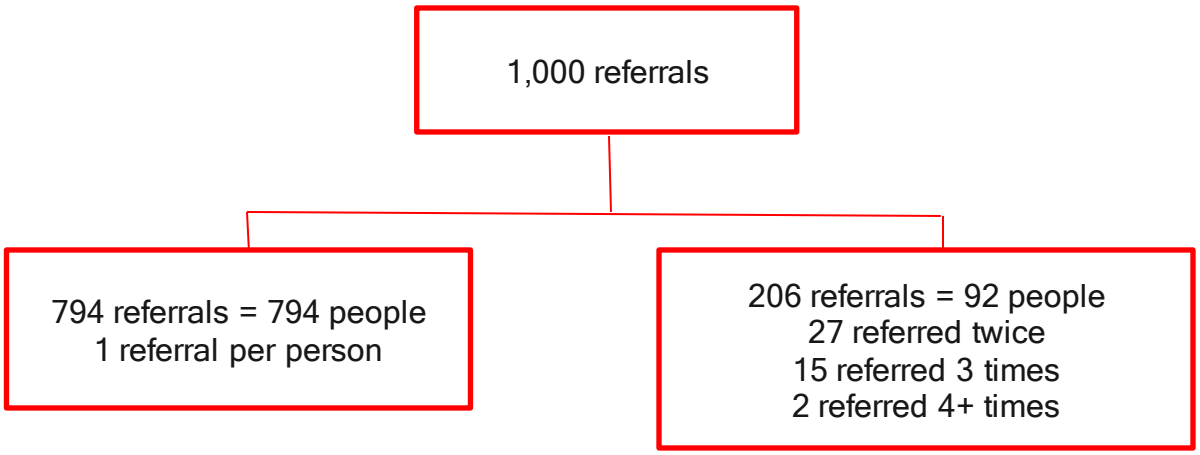
4.1 The dataset

The dataset analysed for the purposes of this evaluation consisted of all referrals logged by 4th February 2022 for both the Out of Hours (OOH) and In Hours (IH) services. This was a total of 5,050 cases:

- 1,737 for OOH (from 26th May 2020) or 34% of the total; and
- 3,313 for IH (from 7th September 2020) or 66% of the total.

The original proposal by GAMH was based on the Renfrew First Crisis service, which suggested 1,200 referrals annually, equating to 2,500 contacts per year. Whilst the number of referrals has been lower for the OOH service, the number of contacts has been significantly higher.

Cases were explored for re-referral and use of both OOH and IH services by the same individuals. As each new call is attributed a unique reference number, this involved a bit of detective work, marrying up identifying information. There is therefore a caveat to this information. Cases were sorted by one identifier and the first 1,000 cases were closely examined for any individuals who appeared more than once, considering date of birth, postcode, referral source, referring issue, qualitative data logged, etc. This found the following:



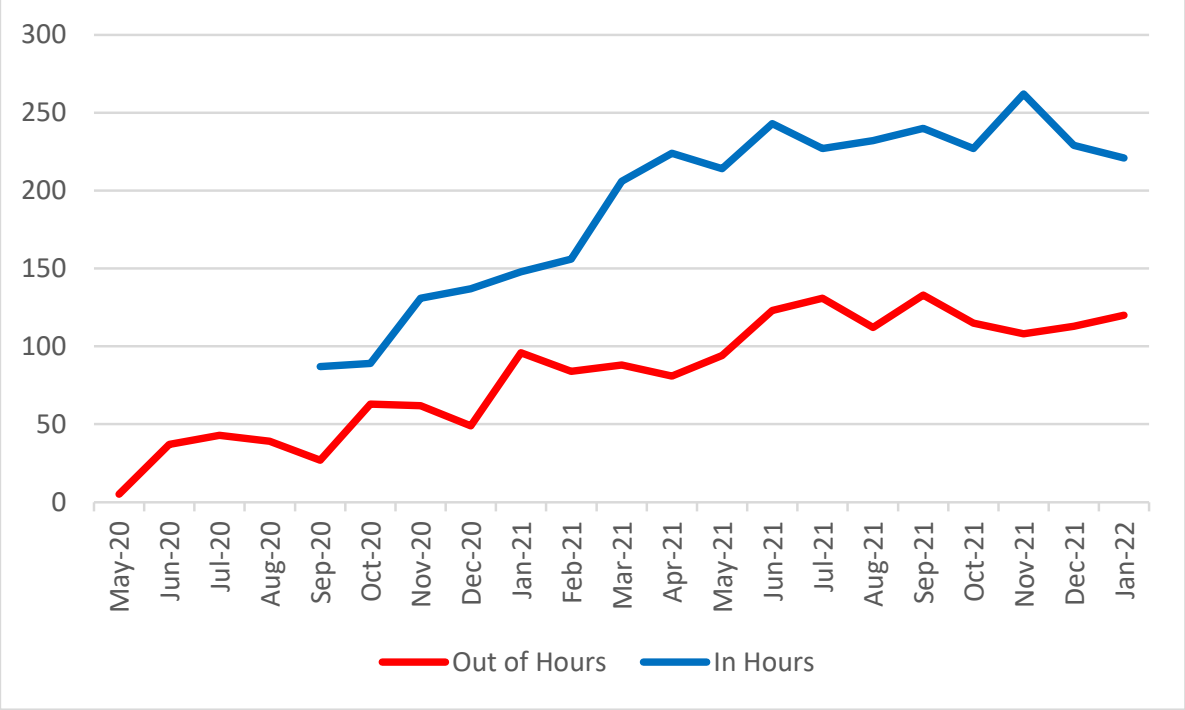
- Non-engagement was an issue for 50% of repeat referral individuals.
- Two declined the service as they felt less distressed once the service contacted them.
- 6 engaged but wanted other services - counselling or clinical mental health services - instead of a compassionate listening service.
- 18 were referred to both the IH and OOH services within a short space of time - some seemingly independent of each other when the individual was very distressed and sought support from their GP and via another means (such as Police taking them to the MHAU), others were referred by the opposite service as their timings suited the individual better to talk.

4.2 Referrals over time

The distribution of referrals is shown for each service by month below in chart and table format. Please note that: the chart does not include the referrals for February 2022 as the data stopped at 4/2/22 and the out of hours service commenced near the end of a month (26/5/20), whilst the in hours service commenced near the start of a month (7/9/20).

The out of hours service was slower to grow referrals than the in hours service and was sitting at approximately half the number of referrals per month for the last six months of the period considered. However, the out of hours service started towards the beginning of the Covid pandemic and its intended referral pathways were much more varied and affected by additional services such as the MHAUs and NHS24 MH hubs coming on stream at the same time.

Figure 1: Number of referrals by month and service



OOH n=1,737; IH n=3,313

Table 1: Number of referrals by month and service

Month/Year	Out of Hours Opened 26/5/20	In Hours Opened 7/9/20
May-20	5	
Jun-20	37	
Jul-20	43	
Aug-20	39	
Sep-20	27	87
Oct-20	63	89
Nov-20	62	131
Dec-20	49	137
Jan-21	96	148
Feb-21	84	156
Mar-21	88	206
Apr-21	81	224
May-21	94	214
Jun-21	123	243
Jul-21	131	227
Aug-21	112	232
Sep-21	133	240
Oct-21	115	227
Nov-21	108	262
Dec-21	113	229

Month/Year	Out of Hours Opened 26/5/20	In Hours Opened 7/9/20
Jan-22	120	221
Feb-22 (only until 4/2/22)	14	40
Total	1737	3313

4.3 Referral Source

All of IH referrals came from Primary Care within Glasgow City HSCP, with at least 88% of the city's GPs and at least 94% of practices having made a referral by autumn 2022. As can be seen from the table below, two-thirds of OOH referrals came from MHAU. Police Scotland and Scottish Ambulance Service have been particularly low referrers to date but this may change in future if expressed wishes to increase referrals transpire, which could have significant impacts on capacity given the greater complexity of the case load out of hours.

Table 2: Out of hours referral sources

	No	%
MHAU	1145	66
OOH CPN	117	7
Emergency Dept	103	6
MHAU via GP Consult Connect	103	6
Psychiatric Liaison	85	5
GP Out of Hours	56	3
In Hours CDRS	39	2
Police Scotland	23	1
Self-referral	18	1
Other	14	1
Scottish Ambulance Service	13	1
OOH Social Work	8	0
Unscheduled Care	6	0
Missing	7	0
Total	1737	100%

Given that two-thirds of referrals were from MHAU, it was not surprising to see that the most common locations of out of hours referrers were dominated by Leverndale (42%) and Stobhill (31%).

Table 3: Location of out of hours referrals, as logged

	No	%
Leverndale	736	42
Stobhill	534	31
QUEH	88	5
GRI	77	4
Caledonia House[36]	51	3
Other/no description	251	14
Total	1737	100%

[36] Out of hours CPNs were based at Caledonia House in the early period of CDRS, prior to MHAUs becoming established.

4.4 Referrals by postcode

The database provided the first part of postcodes only, so analysis of these with approximate area is shown in the table below. The G20 postcode (Maryhill/Ruchill/Firhill) was the most common logged for both services. Out of hours referrals include some people living outwith Glasgow City boundaries as it provides a service to anyone who needs it within the city at the time of their distress and the city centre obviously draws people in from a wider catchment. Paisley (other Paisley postcodes also featured but to a lesser degree) and Clydebank/Duntocher were therefore strongly represented, as were a number of other localities bordering Glasgow.

The North West is the most prolific referral locality for the IH service, accounting for approximately half of all referrals and only one practice in the North West has not referred to CDRS to date. Prolific referrers are a mix of larger practices and smaller practices.

Table 4: Top 25 postcodes for referrals to each service

Postcode/Area		OOH		Postcode/Area		IH	
		No	%			No	%
G20	Maryhill/Ruchill/Firhill	71	4.5	G20	Maryhill/Ruchill/Firhill	331	10.0
G32	Tollcross	67	4.3	G15	Drumchapel	293	8.9
G33	Riddrie	61	3.9	G13	Knightswood	211	6.4
G51	Govan	60	3.8	G32	Tollcross	201	6.1
PA1	Paisley	59	3.8	G22	Milton	196	5.9
G81	Clydebank/Duntocher	57	3.6	G14	Dumbarton Road Corridor	162	4.9
G22	Milton	54	3.4	G51	Govan	153	4.6
G53	Pollok	54	3.4	G42	Govanhill/Toryglen	148	4.5
G31	Parkhead/Dennistoun	51	3.3	G53	Pollok	140	4.2
G13	Knightswood	50	3.2	G52	Cardonald	138	4.2
G42	Govanhill/Toryglen	46	2.9	G31	Parkhead/Dennistoun	131	4.0
G41	Pollokshields/Shawlands	45	2.9	G40	Bridgeton/Dalmarnock/ Calton	112	3.4
G21	Springburn/Royston/ Barmulloch	42	2.7	G33	Riddrie	109	3.3
PA2	Paisley	42	2.7	G23	Summerston	101	3.1
G15	Drumchapel	41	2.6	G41	Pollokshields/Shawlands	86	2.6
G12	West End	38	2.4	G11	Partick/Broomhill	78	2.4
G14	Dumbarton Road Corridor	37	2.4	G21	Springburn/Royston/ Barmulloch	77	2.3
G52	Cardonald	37	2.4	G69	Baillieston/Chryston	77	2.3
G45	Castlemilk	35	2.2	G44	Kings Park/Croftfoot/ Cathcart	72	2.2
G40	Bridgeton/Dalmarnock/ Calton	32	2.0	G3	Yorkhill/Finnieston/Park	65	2.0
G66	Kirkintilloch	32	2.0	G43	Pollokshaws/Mansewood /Newlands	59	1.8
G11	Partick/Broomhill	30	1.9	G5	Gorbals	59	1.8
PA3	Paisley	29	1.8	G46	Thornliebank	48	1.5
G44	Kings Park/Croftfoot/ Cathcart	27	1.7	G45	Castlemilk	44	1.3
G46	Thornliebank	27	1.7	G12	West End	43	1.3

Not all referrals included a postcode so n=1,568 for OOH and n=3,296 for IH

4.5 Ethnicity

The ethnicity of referrals was predominantly White for both OOH (754/92% of known ethnicity) and IH (1,696/89% of known ethnicity), although there was a much higher proportion of White British (438/23%) referred to the in hours service as opposed to White Scottish (1,252/66%) in comparison to out of hours (14/2% and 736/90% respectively). Asian referrals were higher for the in hours service (91/5%: 51 of whom were Pakistani) than the out of hours service (15/2%), whilst a similar proportion of Black referrals were received by each service (10/1% OOH; 24/1% IH). The service has received a number of referrals from refugees and asylum seekers, some of whom have experienced significant trauma.

However, it should be noted that ethnicity was not well recorded on the database, with 53% of OOH and 43% of IH referrals not logging this information. Given the degree of missing data on this it is hard to say how representative or otherwise the referrals to CDRS of the wider Glasgow population. OOH also has a catchment beyond Glasgow City alone. For information, the ethnicity of Glasgow City[37] shows greater diversity, with 84% White Scottish/British/Irish, 8% Asian, 2% African, 4% other White and 1% other ethnic groups.

Please note that ethnicity was gathered via an expanded list but is aggregated here given the small numbers.

Table 5: Known ethnicity by service

Ethnicity	OOH n=821		IH n=1898	
	No	% of known ethnicity	No	% of known ethnicity
White (Scottish/British/Irish)	754	91.8	1696	89.4
Asian (Pakistani/Bangladeshi/Chinese/ Indian/Other Asian)	15	1.8	91	4.8
Black (Caribbean/African/Other Black)	10	1.2	24	1.3
Other	42	5.1	87	4.6

4.6 Age at referral

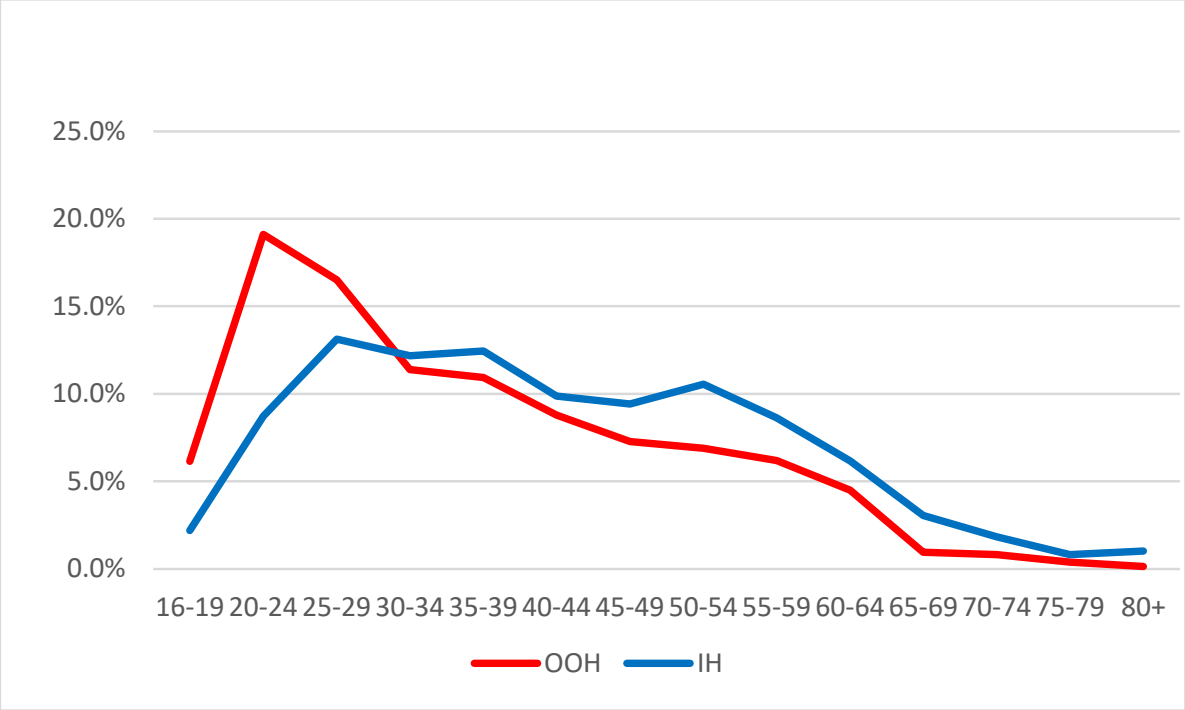
The age of individuals at the time of referral was also calculated for those where date of birth was present. The figure below illustrates that the out of hours service received a higher proportion of younger referrals than in hours, but both received referrals across the full age spectrum. A quarter (399/25%) of out of hours referrals were aged 16-24 and just over a half (840/53%) were aged 16-34, with 4 out of 5 (1,267/80%) aged under 50 and just 2% (36) aged 65+. The mean (average) age was 36, median (midpoint) age was 33 and mode (most common individual age) was 22 (70 referrals).

In contrast, just 1 in 9 (357/11%) in hours referrals were aged 16-24 and just over one third (1,184/36%) were aged 16-34, with two-thirds (2,222/68%) aged under 50 and 7% (829) aged 65+. The mean age was 42, median age was 40 and mode was 28 (104 referrals).

The data for each five year interval is also shown in the table below for information.

[37] 2020_HSCP_Demographics_Profile_0.pdf

Figure 2: Age at referral in 5 year bands, by service



OOH n=1,581; IH n=3,271

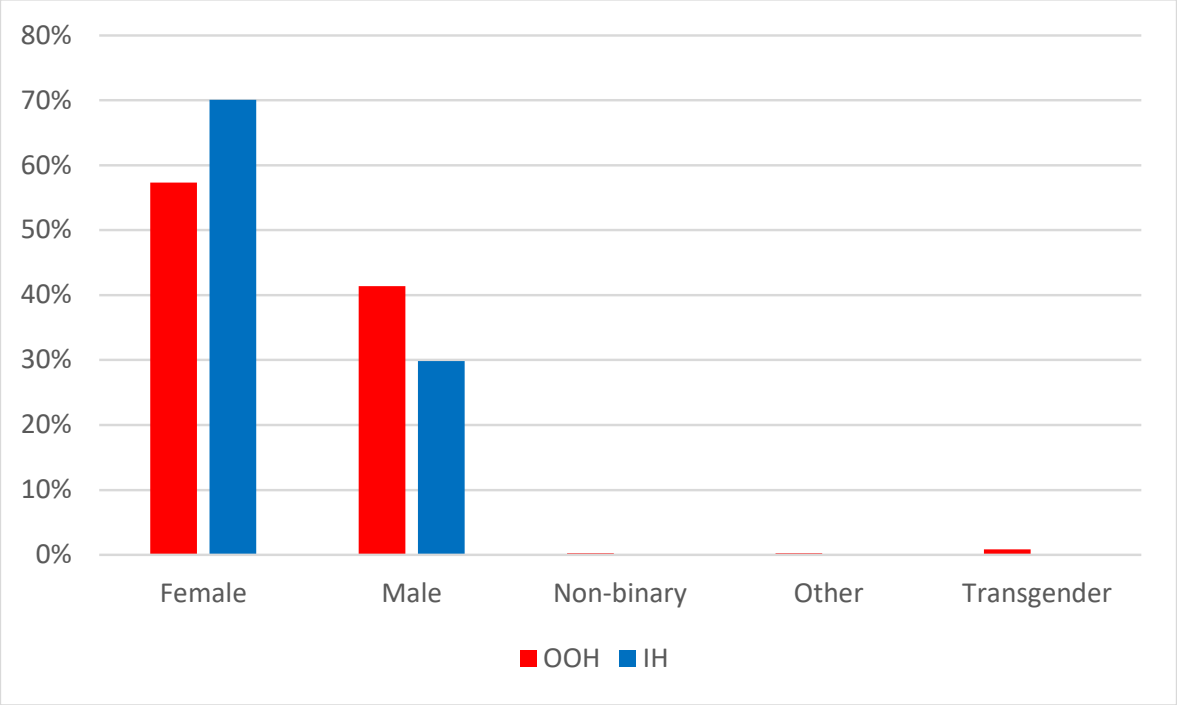
Table 6: Age at referral in 5 year bands, by service

Age	OOH n=1,581		IH n=3,271	
16-19	97	6.1%	72	2.2%
20-24	302	19.1%	285	8.7%
25-29	261	16.5%	429	13.1%
30-34	180	11.4%	398	12.2%
35-39	173	10.9%	407	12.4%
40-44	139	8.8%	323	9.9%
45-49	115	7.3%	308	9.4%
50-54	109	6.9%	345	10.5%
55-59	98	6.2%	282	8.6%
60-64	71	4.5%	202	6.2%
65-69	15	0.9%	100	3.1%
70-74	13	0.8%	60	1.8%
75-79	6	0.4%	27	0.8%
80+	2	0.1%	33	1.0%

4.7 Gender

More females than males were referred to each service, although there was a heavier female bias for the in hours service, where 70% (2313) were female (where gender was known) and 30% (985) were male. The out of hours service had 57% (975) female referrals and 41% (703 male) referrals. The out of hours service also had 14 transgender referrals, 4 non-binary and 4 other gender. The in hours service also had 2 transgender referrals.

Figure 3: Gender of referral, by service



OOH n=1,700; IH n=3,300

4.8 Other characteristics noted

The database also revealed the following:

- 21% of out of hours referrals, where recorded (332 of 1,568) had prior contact with the Police: 19% (168) of female and 24% (156) of male referrals. In contrast, just 8 (less than 1%) of in hours referrals had prior contact with Police: 5 females and 3 males, according to the database. This may be due to who completes this field, however, as a GP may not know or share this information and whilst it may emerge from conversation with CDRS it may not be logged in this field by the team.

- 17% (288) of out of hours referrals were recorded as currently engaged with mental health services, in comparison to just 1% (47) of in hours referrals.

- 9% of out of hours referrals (150) and 6% of in hours referrals (188) were recorded as having children under 18 living at home. 3% (49) of out of hours referrals had children involved with Social Work and 1% (42) of in hours referrals.

- A greater number of additional support needs were logged for out of hours referrals - 49 compared to 3 in hours. These included Autism/ASD, Learning Disabilities, sensory impairment, dyslexia and English as a second language, for example.

- One in ten of out of hours referrals (10%/181) had known health issues and one in twenty of in hours (5%/163), with a higher proportion of out of hours referrals also on medication (19%/334; 12%/414 in hours).

4.9 Risks or concerns

79% of out of hours referrals (1,368) flagged a risk or concern for CDRS to be aware of compared to 11% (363) of in hours referrals. This may be due the way in which risks are logged (referrers may not have explored these risks or concerns in the same way as out of hours referrers, for example). Whilst some in hours referrals involved risk and concerns, they were generally much lower than the levels logged on the database for out of hours referrals, as can be seen in the table below:

Table 7: Risks and concerns of referrals, by service

Risk/concern	OOH n=1,737		IH n=3,313	
	No	%	No	%
Risk/concern to be aware of	1368	79%	363	11%
Person feels at risk of suicide	1117	64%	406	12%
Self-harm behaviour	516	30%	157	5%
Offending/pending court	141	8%	30	1%
Drug/alcohol abuse	651	37%	130	4%
Violence or aggression	150	9%	33	1%

4.10 Number and duration of calls

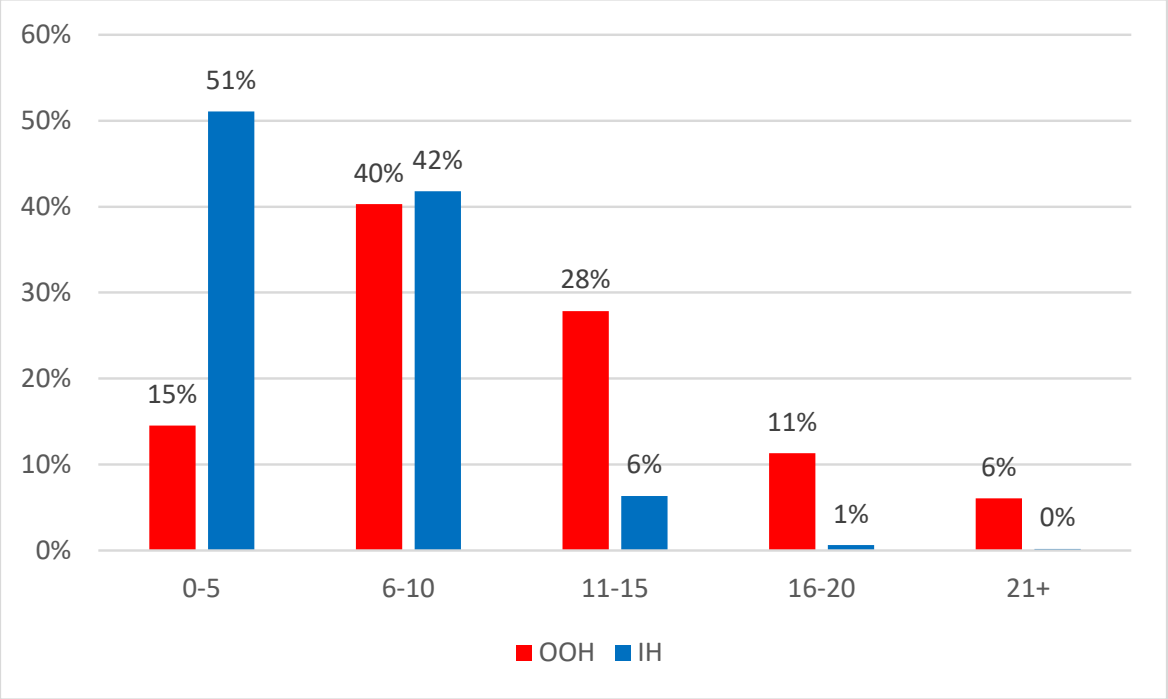
The referrals database logged the total number of calls and the total duration of calls per referral. Analysis of this reveals the following:

Table 8: Total number and duration of calls, by service

	OOH n=1,737	IH n=3,313
Total number of calls	18,913	18,781
Average (mean) number of calls per referral	10.9 calls	5.7 calls
Highest number of calls to one referral	56 calls (10 hours 47 minutes total duration)	33 calls (6 hours 36 mins total duration)
Total duration of calls	150,596 minutes (2,509 hours and 56 minutes)	115,438 minutes (1,923 hours and 58 mins)
Average duration of calls per referral	87 minutes	35 minutes
Longest duration of calls to one referral	1,869 minutes (31 hours 9 mins) over 52 calls	469 minutes (7 hours 49 minutes) over 11 calls
Number of calls without success	197	354

The figure below illustrates the greater number of calls per referral undertaken by the out of hours service, with just 15% (252) receiving less than 6 calls in comparison to 51% (1,692) of in hours referrals. The services had similar proportions of 6-10 call referrals (40%/700 OOH and 42%/1,384 IH) but out of hours made 11+ calls to 45% of referrals (785) in comparison to 7% (237) of in hours referrals.

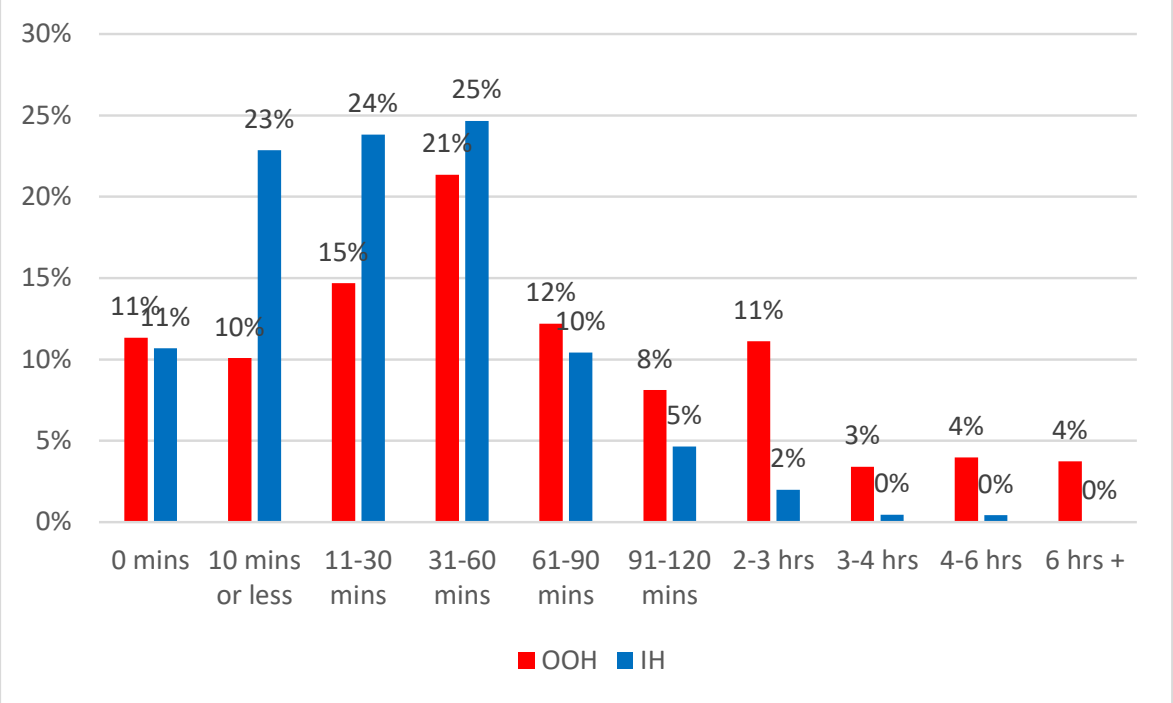
Figure 4: Number of calls per referral, by service



OOH n=1,700; IH n=3,300

The intensity of the out of hours service in terms of total duration of calls per referral was also notable and illustrates why there was a difference in the average call duration. Whilst each service had a similar proportion of 0 minute calls at 11% (i.e. they did not speak to clients, despite trying several times), 82% (2,717) of in hours referrals received less than an hour of support in total, in comparison to 57% (998) of out of hours referrals.

Figure 5: Cumulative duration of calls per referral, by service



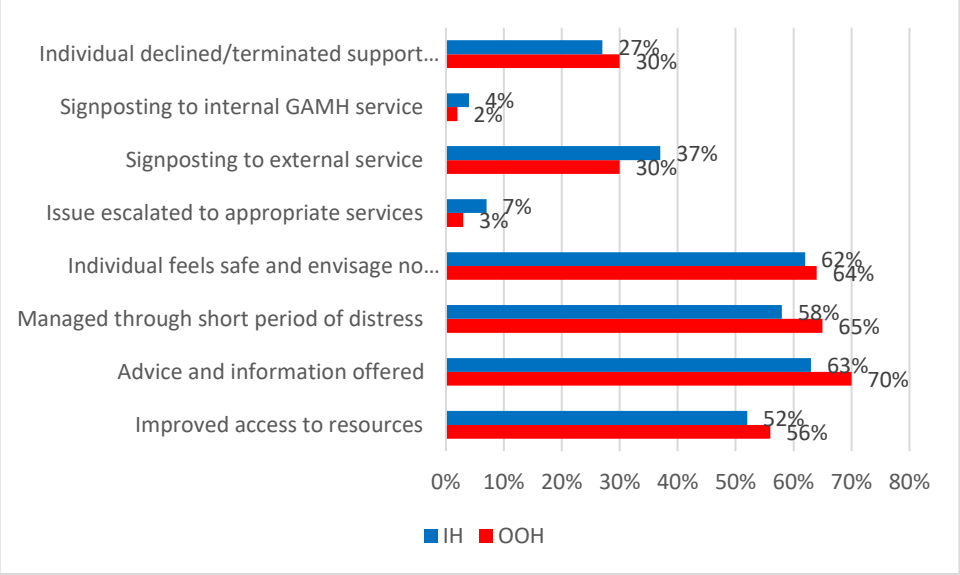
OOH n=1,700; IH n=3,300

4.11 Outcomes of calls

The outcome of each referral was logged on the database and these were similar for each service, as can be seen in the figure below. 70% OOH/63% IH referrals (1,209/2,077) had been offered

advice and information, 65% OOH/58% IH (1,137/1,922) had managed through a short period of distress, with 56% OOH/52% IH having improved access to resources. Over 3 in 5 (64%/1,110 OOH and 62%/2,039) referrals logged that the individual feels safe and no injury or harm was envisioned. Given that 30%/517 OOH and 27%/903 IH referrals declined or terminated support, this represents the vast majority of those who engaged.

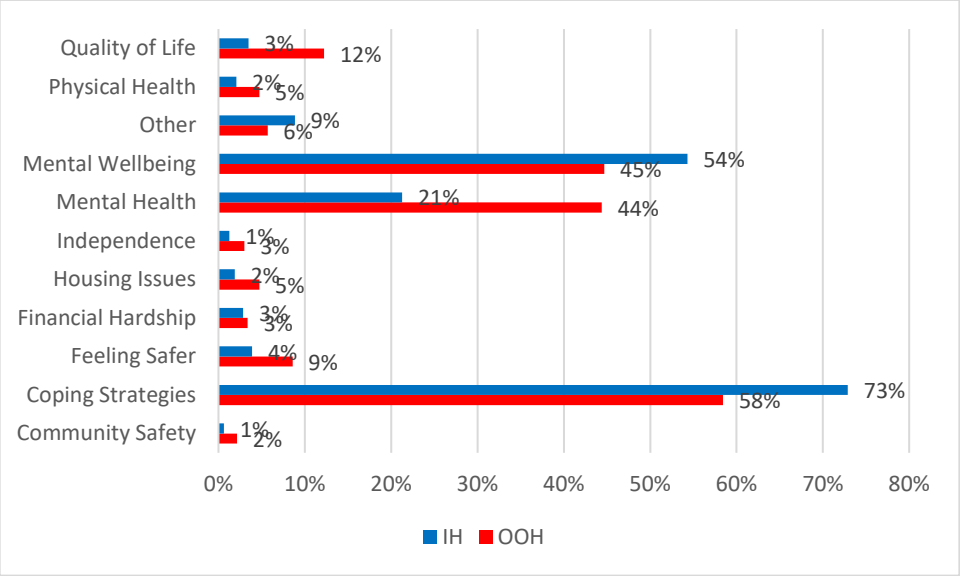
Figure 6: Outcomes logged on referral database, by service



OOH n=1,700; IH n=3,300

To flesh this out further, the database logs up to three outcomes for each referral, from a pre-selected list. For both OOH and IH services, where outcomes were recorded, the top three options selected for each outcome and when aggregated were Coping Strategies (OOH 607/58%; IH 1,279/73%), Mental Wellbeing (OOH 464/45%; IH 953/54%) and Mental Health (OOH 461/44%; IH 273/21%). As can be seen from the figure below, Coping Strategies and Mental Wellbeing were more commonly selected for in hours referrals, whilst Mental Health was twice as likely to be logged for out of hours referrals. Coping Strategies was the most common outcome logged as Outcome 1, followed by Mental Health for OOH and Mental Wellbeing for IH. Mental Wellbeing was the most commonly logged Outcome 2 & 3 for both services.

Figure 7: Aggregated 3 outcomes logged, by service



OOH n=1,039; IH n=1,755

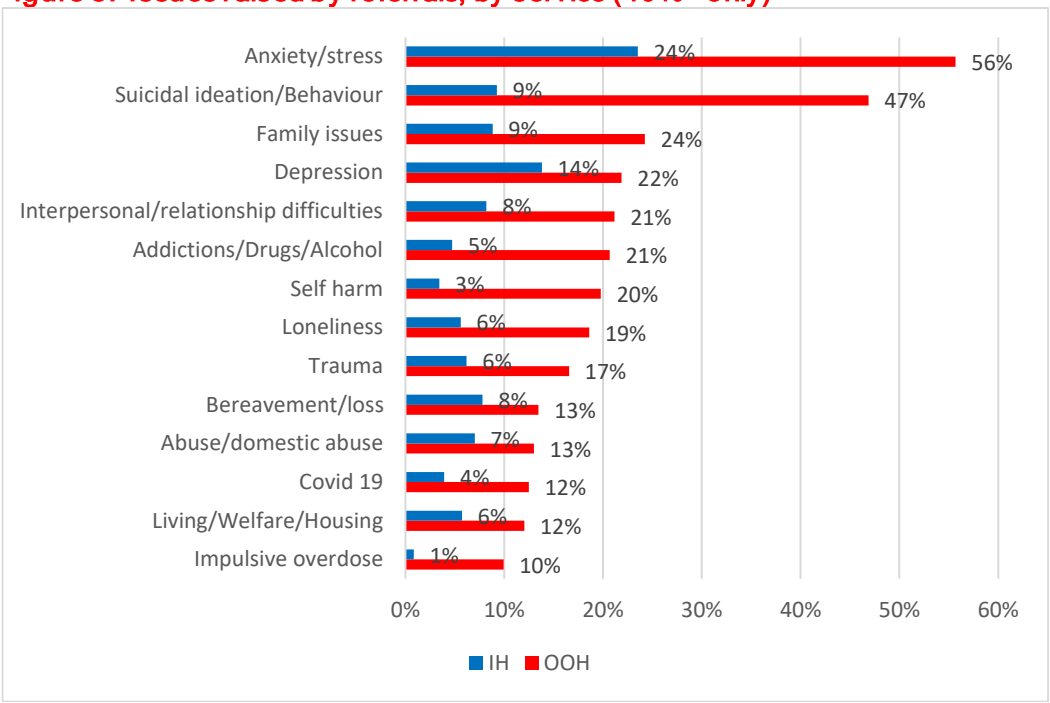
4.12 Issues raised

The issues each referral has raised during discussion is also logged, from a checklist of 31 issues. Consistent with previous data, more issues were raised by out of hours referrals with a total of 5,775 issues raised across 1,523 referrals to give a mean of 3.8 issues per referral. In comparison, a total of 4,014 issues were raised across 2,833 in hours referrals to give a mean of 1.4 issues per referral. That is not to say that no referrals to the in hours service were complex, however, as the minimum and maximum number of issues logged for each service was the same: the lowest number was 1 and the highest was 15. The number of issues raised at referral was often lower than the number which emerged over the course of discussions, as might be expected, and the distress which was presented was much more heightened and serious than had originally been conveyed.

The issues highlighted during discussions with 10%+ in either service are shown in the figure below, with the full list in the following table. Anxiety/stress was the most commonly featured issue for each service but suicidal ideation/behaviour was nearly as high for the out of hours service, with nearly half of all cases with data on this featuring this issue (47%/714), with an additional 10% (151) citing impulsive overdose and 20% (301) deliberate self-harm. The second highest scoring issue for the in hours service was depression (14%/391).

Please note that 'suicidal ideation/behaviour' and 'impulsive overdose' are two separate categories and whilst there is some overlap between the two, these were not both logged in many cases. This is also the case for 'abuse' and 'domestic abuse', where there was not a great deal of overlap.

Figure 8: Issues raised by referrals, by service (10%+ only)



OOH n=1,523; IH n=2,833

Table 9: Full list of issues raised by referrals, by service

Issues	OOH N=1,523		IH N=2,833	
	No	%	No	%
Anxiety/stress	848	56%	666	24%
Suicidal ideation/Behaviour	714	47%	262	9%
Family issues	369	24%	250	9%
Depression	333	22%	391	14%
Interpersonal/relationship difficulties	322	21%	232	8%
Addictions/Drugs/Alcohol	315	21%	134	5%
Self harm	301	20%	97	3%
Loneliness	283	19%	158	6%
Trauma	252	17%	175	6%
Bereavement/loss	205	13%	221	8%
Covid 19	190	12%	111	4%
Living/Welfare/Housing	183	12%	162	6%
Impulsive overdose	151	10%	24	1%
Physical health/illness	140	9%	160	6%
Insomnia	140	9%	142	5%
Abuse	124	8%	125	4%
Work/Academic/Training	119	8%	127	4%
Personality/challenging behaviour	109	7%	51	2%
Anger issues	96	6%	86	3%
ACEs	84	6%	60	2%
Money/debt issues	79	5%	73	3%
Domestic abuse	73	5%	62	2%
Eating issues	71	5%	44	2%
PTSD	65	4%	57	2%
Autism	45	3%	27	1%
Carer	44	3%	53	2%
Psychosis	32	2%	9	0%
Bullying	30	2%	18	1%
Education	23	2%	14	0%
Cognitive learning	23	2%	10	0%
Pregnancy loss	12	1%	13	0%

5 Experiences of CDRS

5.1 Introduction

This section outlines the feedback provided by all the stakeholders who gave their views for the evaluation. The views of people who use the service, referrers, CDRS staff team and other stakeholders are presented under each key theme explored. These topics are as follows:

- awareness and understanding of CDRS;
- the referral process;
- numbers referred;
- method of contact;
- barriers to referral or service uptake;
- rating of the service;
- confidence in the service;
- what's working well;
- challenges;
- communications and partnership working;
- perceptions about CDRS being a Third Sector provider;
- how it compares to other services;
- USP;
- suggestions for improvement or areas for development; and
- future sustainability.

Impacts are noted in the next section.

5.2 Awareness and understanding of CDRS

Discussions with stakeholders commenced with establishing their awareness and understanding of what CDRS does and does not do.

5.2.1 Out of hours service

Awareness of the Out of Hours CDRS for those interviewed was very good, although some recognised that others in their services may have more mixed or limited awareness. This was not the case for high referrers such as the Mental Health Assessment Unit but was for Police Scotland and the Scottish Ambulance Service. Other NHS referrers such as Psychiatric Liaison and Emergency Department teams felt there was probably a reasonable awareness of CDRS but that may not convert into referral for all staff members, as other services may be more expedient, front of mind or appropriate for patients.

It is noted that CDRS senior staff have put a lot of effort into making services aware of what they do and encouraging referrals. For example, by setting up meetings as one-offs or on a regular basis as with MHAU to build awareness, shared understanding and positive working relationships.

The service was planned and commissioned just before the pandemic so unfortunately launched at a challenging time for all services, and the Mental Health Assessment Units and NHS24 Mental Health Hubs came into play around the same time. Whilst the CDRS and MHAU have an excellent working relationship, understanding and strong referral pathways - the MHAU is the largest referrer to Out of Hours CDRS - other front line first responders such as Police Scotland and the Scottish Ambulance Service are more likely to know and take people to the MHAU than to CDRS directly.

> *"People in distress rarely end up in mainstream mental health services [unless they have already had a diagnosis] so CDRS was designed as a more appropriate place for them to go."* OOH referrer, MHAU

> *"I heard about CDRS on my first day and it was all positive. Four or five staff members I was working with in my first week spoke very highly of it so I made contact in my first week. There's also a lot of material about CDRS in the department."* OOH referrer, MHAU

Police Scotland have not prioritised CDRS as a service provider to date, but this may shift with a recent change in leadership locally. It is easy to say that Police Scotland is 'risk averse' and its own officers are upfront that risk is a consideration, but this is understandable as officers are liable to investigation should anyone they have been in contact with comes to harm (e.g. dies by suicide) up to 72 hours afterwards. Taking risks can therefore have a significant impact on them as individuals. However, police officers are clearly dealing with call outs to distressed people, often facing a variety of social issues, who do not have a mental health condition so do not need the MHAU, but do need support of some kind to help them through a difficult time. It has been widely publicised that a high proportion of Police call outs do not relate to a crime and there will inevitably be people in or leaving custody who are in psychological distress.

Similarly, the Scottish Ambulance Service has been under significant stress during the pandemic so raising awareness of the CDRS has not percolated through to front line responders in the way it had originally been intended. There is interest in changing this, however, and work is ongoing to develop and share referral pathways and information with crews.

5.2.2 In hours service

Seven out of eight GPs (88%) and at least 94% of practices in Glasgow City have now referred to CDRS which illustrates that awareness of the service is high. Most GPs interviewed had become aware of the service via an email newsletter, or it was assumed that was the source if they were not sure. Several suggested that information was circulated when the service was first launched, in 2020 so recall could easily be affected by elapsing time. The co-ordinator of the in hours service has also raised awareness with practices and specific workers (such as link workers and nurses) directly to encourage referrals.

As noted earlier, despite significant efforts, no interviews were achieved with non-referring practices. One GP felt they did not really know what CDRS did and how it differed from other services like Breathing Space or other PCMHT services. They had referred a couple of patients but had not received feedback from CDRS and the feedback from patients was not positive as *"it's just a listening service and there's no need for me to tell my story"*. This lack of full understanding of what CDRS does had affected their view on future referrals so *"I've stopped referring and it wouldn't be the first on the list for patient referrals"*. However, by the end of the interview this GP felt they had a better understanding of the service and was keen to refer in future and was also planning to encourage colleagues to do so. The service has since trialled and embedded routine feedback to Primary Care referrers (with the person's consent).

Community Links Workers all said that the CDRS had been raised during training. One highlighted that the service had provided an introduction to CDRS and clearly outlined who to refer and what to do. This was very helpful, particularly in emphasising the importance of language used (by them and patients) to ensure referrals are appropriate and when other services such as Primary Care Mental Health Teams may be more appropriate. This clarification with examples was found to be very helpful.

> *"Probably not at first but [the co-ordinator] came out and had a chat with us, then it was much easier to know who might benefit."* IH referrer

> *"The language is very good - it's about acute distress. There's a tendency in mental health services to give everything a mental health label or to delay/prohibit access [to support] but the lovely CDRS doesn't do that. Distress can be caused by many issues, many of which are not a mental health condition but social issues. We have very vulnerable patients."* IH referrer, GP

5.2.3 People using the service

Similarly, people using the service reported a mix of understanding of what CDRS was about at the point of referral – which is understandable given the circumstances of their engagement/distress they were in at the time – but their first contacts with CDRS clarified what it was/was not and what it could/could not do for them. Unless they had been referred before, they had not been aware of the service prior to referral.

> *"It's different to what my GP said it was, but it's better than what they said it would be."* Person who engaged with CDRS

> *"I'm not sure if anyone really explained what it was, but they did when they called so that was fine."* Person who engaged with CDRS

5.2.4 Understanding of the service

The majority of those who gave their views on either the OOH or IH services were comfortable that they knew what the service could do and who it was designed to support. It was generally perceived to be for those who are distressed by social stressors such as relationship breakdown, bereavement, work or money worries who need some support at a difficult time.

> *"If it's not relevant to refer them elsewhere, I'll send them to CDRS. There's something causing them to present and CDRS can help. It's hard if there's nothing to give them other than their own GP or the Crisis Team. CMHT isn't always appropriate. CDRS fits right in between them and will have a good chat with them and guidance."* OOH referrer, MHAU

> *"CDRS is a quick fix for people and for us. There's no point referring them to a service with a long waiting list if they're crying out for help, they need it now."* OOH referrer, MHAU

> *"If it's personality disorder it can be very challenging to deal with. If they're difficult and trying to get admitted I won't refer them to CDRS."* OOH referrer, MHAU

> *"There's no real pattern to when people become distressed in terms of time of day or day of the week, but there is a pattern in terms of people go to see the GP at the last minute when they can't cope and are at the 'bubbling' stage."* IH referrer

> *"I've referred a few. I know it's just for distress not the drip drip anxiety that a lot of people have but people want a silver bullet so some expectations are high and 'just a listening service' is not for some complex cases. We talk about what they have done and what has been useful so far then decide the best referral route."* IH referrer

Distress was perceived to be a 'normal response' to the issues people were facing, but nonetheless they needed some support from someone not involved in the situation or because they had no-one to share their concerns with. The same words were used repeatedly by participants to describe what CDRS is:

> *"a listening ear"*
> *"a compassionate listening service"*
> *"giving people the opportunity to talk and be heard"*
> *"a short term crisis intervention"*
> *"practical advice and emotional support"*

and is not:

> *"not if they're actively suicidal"*
> *"It's not counselling!"*

Referrers in primary care and OOH referrers found they refer to CDRS alone, alongside other supports such as a Links Worker or while people are waiting for an appointment with another service with a longer lead in time.

> *"I often refer to both the Link Worker and CDRS, for example if there are housing, benefits and social issues. It's rare for patients to decline. I've only had positive feedback."* IH referrer, GP

GPs raised the issue of their and their teams' time being limited, so if a patient has ongoing needs and they are *"still in a queue"* for support from mental health services it can be extremely challenging for them – with repeated but non-productive appointments – and the patient. The rapid response of CDRS to alleviate distress and helping patients to improve coping skills was greatly welcomed to assist with these patients and others in distress. However, GPs also highlighted that whilst CDRS is *"great at alleviating crisis [for patients] there's nowhere else to go after that, which some people need".*

5.3 Referral process

The referral process for both the OOH and IH services is just one page as a starting point for discussion and was seen to be quick and straightforward. Referrers to OOH reported that they called the first few times or if they felt they had to give a bit more background on a patient, but email was also convenient and the only way to refer before or after service delivery hours.

> *"It's really easy, appropriate and quick. It can be helpful to have a quick discussion first."* OOH referrer, MHAU

GPs reported that they would also refer by phone if the patient had a more complex situation, they were particularly concerned for them or when they were first using the service. SCI Gateway was highlighted as an expedient means of referring a patient quickly, which GPs could also ask staff to complete on their behalf.

> *"They're very easy to refer to, unlike Community Mental Health Teams, and if we get feedback from patients, they've been dealt with really well and taken action. Feedback has all been very good."* IH referrer, GP

> *"I tend to refer through SCI Gateway. It's easy and quick more than anything and it can be tricky to phone with people coming in or if I have someone in the room with me. It's very easy, I haven't had any problems. I would phone if there was more of an issue and have a wee chat so I'm confident they know what's going on."* IH referrer

All referrers felt the correct information was sought during the referral process, nothing critical was missing and it wasn't overly bureaucratic. The universal view was that it works well for them.

> *"It gets the necessary information without being too long or complicated. There's nothing missing."* OOH referrer, MHAU

> *"It's just a phone call. It's very quick and painless, nothing unnecessary asked just pertinent questions to give the background about the patient, if there is suicidal ideation or other risks, etc. I don't dread it. It's a very professional set up."* IH referrer

> *"Referral is much quicker, don't ask for as much info as CAMHS or CMHT but ask what is required."* IH referrer, GP

In some general practices, only the GP or Link Worker referred to CDRS but in others reception staff also did so.

"We all use it [CDRS] and like it… There's always a lot of distress." IH referrer, GP

"I like that our staff feel confident to signpost, including reception staff and they are willing to speak to reception staff [unlike other mental health services]." IH referrer, GP

"There is a natural reluctance of, for example, reception staff to refer patients to services like CDRS, but they see all the burn out too and the difficult backgrounds [of patients]. They know it's ok to refer but hard to get them to do it as they feel safer to run it past the doctor first." IH referrer, GP

5.4 Numbers referred

The research aimed to gather a mix of views so some referrers interviewed had referred just one or two people to the service, whilst others stated that they referred every shift. The lowest estimate was 1 or 2 referrals in total for each service whilst others felt they referred on a daily or weekly basis. This varied by type of role, size of practice and/or the profile of their catchment area.

IH referrers

"I refer on a daily basis. I've referred two people already this morning!" IH referrer

"I'm an aggressive referrer. As soon as they were set up I hit the ground running but I've seen other services fail because they didn't have enough referrals at the start and I didn't want that to happen here. There is still a bit of lack of awareness but I can't believe it's as easy or as good as it is." IH referrer, GP

"Referrals come in fits and starts. Nothing for a month then 3 in a row. Probably one or two a month on average." IH referrer, GP

OOH referrers

"There are no barren periods, there's at least one per shift." OOH referrer, MHAU

"I refer people all the time. If they weren't there I'd be gutted. It's a very good service and a good option for people I see, giving them a good level of practical support." OOH referrer, MHAU

5.5 Method of contact for people using the service

The original plan was for there to be a mix of face to face and telephone support for people for both services. Referrals to OOH by Police and Ambulance staff were anticipated to involve people being dropped off at GAMH's city centre office and a quiet room was available to facilitate discussion with people in distress.

The mixed mode of support recognised that some people would prefer to speak more 'anonymously' on the phone or have caring commitments which would make a visit more challenging, whilst others would prefer to talk face to face and/or may wish to be out of home so they could speak more freely. This applies to both OOH and IH services.

There was also an intention to conduct some outreach support to people in their own homes or another venue, and the IH service has conducted a small number of home visits as appropriate.

However, the impact of Covid-19 focussed everyone on reducing face to face contact as far as possible. The vast majority of people using the service to date have done so via telephone calls. Some of the people who used the service who were interviewed had visited GAMH for face-to-face meetings and found this to be very helpful. There have also been a small number of recent home visits for the in hours service.

5.6 Barriers to referral or service uptake

5.6.1 No caller ID

The fact that CDRS has called from a 'No caller ID' number was cited as a barrier by many referrers, as they felt individuals would commonly not answer a call if they did not know who it was from and this was confirmed by people who used the service. CDRS got round this once they had made contact as they arranged when to call again and remind them it would come from an anonymous caller, but it was an issue when first attempting contact and may have impacted on the number of attempts to reach people.

It is understood that this has now been changed so that a number does appear – so people can see that it is CDRS, having been informed of this at referral – although it does not receive incoming calls. Not being able to contact the service was perceived to be unhelpful by some people who had engaged, for example if something else had arisen so they would not be able to make the scheduled call, they had no way of letting CDRS know this and it felt rude.

5.6.2 No self-referrals

The lack of self-referral routes was also raised, particularly by GPs, as they felt this would cut out the need for them to see patients, particularly if they had used the service before. CDRS is wary of self-referral as it is harder to manage in-coming calls. Currently all calls are scheduled following referral rather than guaranteeing an immediate response. There is an important safety issue behind this: they may not be able to gather key contact information such as an address which is important if the person calling deteriorates and an ambulance or the police need to be despatched to ensure their safety. Unscheduled incoming calls may also impact on the schedule of outgoing calls to those the service is already supporting or to referrals from other sources.

> *"We did ask if we could give the mobile number out for people to call direct but the fear is that they store it and keep calling."* OOH referrer, MHAU

5.6.3 Not always the right service or the right time

A barrier to service uptake which was raised by one GP group which was less positive about CDRS overall was that some patients who had been referred to CDRS before refused a later referral. This was because they did not want this kind of service and were clear that they wanted something specific such as counselling or CMHT. Whilst the GPs may have found this to be a negative as they didn't have a quick referral route for these patients, this clarity avoids some inappropriate referrals to CDRS and the frustration of non-engagement: an honest 'no' is often preferable to a dishonest 'yes'.

> *"Not all patients will take a referral to CDRS. Some have tried it once but are very vulnerable, with complex backgrounds, and they just want to get to the mental health team. They don't want CDRS."* IH referrer, GP

> *"I had one patient recently who has had a lot of contact with the mental health team and deteriorated recently so spoke to the mental health team but the CPN felt they didn't justify support so they came back to me and I referred them to CDRS. The patient didn't engage as they didn't feel it was for them."* IH referrer, GP

Opening the service up to Third Sector referrals was also seen to be an option to consider for the future but involved risk and concerns around workload, safety, (in)appropriate referrals and compromising the core support to the statutory sector. A period of consolidation of the current approach was preferred in the short term at least.

5.6.4 Perceptions of the role of CDRS

Several referrers to both OOH and IH highlighted that they refer to CDRS to support an individual whilst they are waiting for another service such as Lifelink or CMHT. However, others had not considered this before, when asked, so this may be useful to promote as part of a package of support which can be offered to people.

> *"I've not thought of CDRS while patients are waiting for other services. I tend to work with them on grounding techniques and teach them a bit of basic CBT regarding their thoughts and feelings or behaviours, breathing or distraction techniques. It's not a deep dive though, just to identify triggers, label it and cope but people don't want to practice, that's the real challenge."* IH referrer

5.6.5 Geographic boundaries

IH CDRS is available to primary care in Glasgow City only but OOH CDRS serves anyone within Glasgow at the time of their distress, including those who live outside the city, as the city is a hub for a much wider catchment. The latter was perceived very positively by Police Scotland and Scottish Ambulance Service as that meant one less criterion for them to check if they were responding to a call regarding someone in distress. However, the MHAUs, Police Scotland and Scottish Ambulance Service all cover a wider geographic area which can be a barrier or frustration for staff to find which distress service the person should be referred to. It was also noted by MHAU that there is no distress support provision in East Renfrewshire, no Third Sector support overnight for referrals but all other areas are covered by different services.

5.6.6 Streamlining the journey

Referrals from the MHAUs make up the majority of out of hours CDRS referrals but this may have involved several 'steps' for the individual in distress, e.g. Police and/or Ambulance to A&E and/or MHAU. This was counter to key aims of CDRS: to reduce the 'journey' for people, and the number of people to whom they had to tell their story. This was recognised by MHAU staff and Police, but is a complex point in practice which we will come back to later in the report.

> *"MHAUs are the biggest referrers to CDRS but it should be the other way about if things had worked out the way they were meant to."* OOH referrer, MHAU

On the upside, it means CDRS receives generally appropriate referrals and it allowed the new team to embed skills/resources and give people the time they needed.

5.6.7 Readiness to engage

The out of hours service has a target to contact all people referred to them within an hour of referral. As many of these have spent some time with Police, Ambulance crews, MHAU, A&E and/or NHS24, they may already be tired, have had to answer a lot of questions, be recovering from drugs, alcohol, self-harm or suicidal behaviours as well as whatever was causing distress. For many, the first call is therefore to introduce the service and find a convenient time to call back, often the next evening once people have had a chance to rest and recover in order to be able to engage.

5.6.8 Reaching the frontline referrers

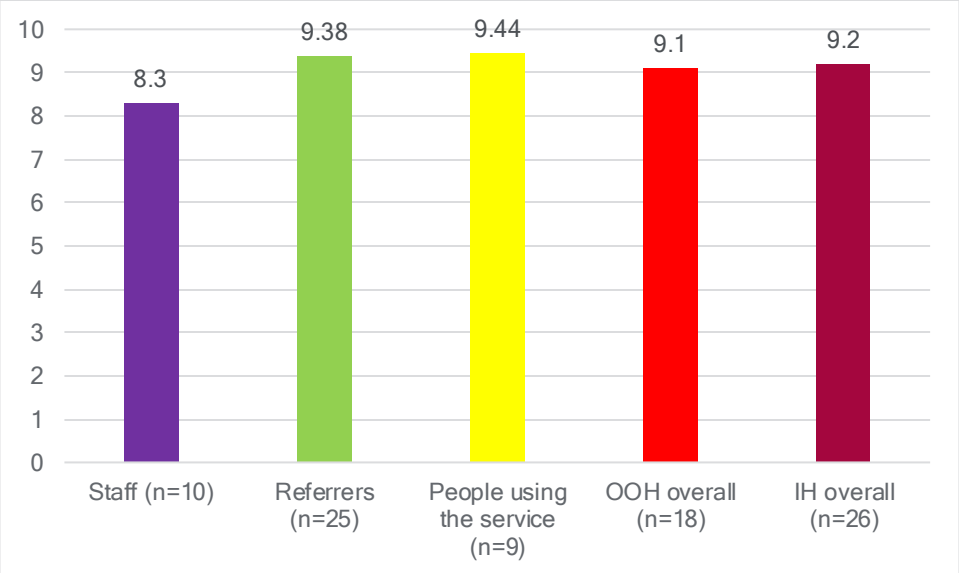
CDRS leadership have put a great deal of time and effort into contact with potential referring agencies to communicate what the service offers and how it can help. This has proved fruitful with MHAUs and general practice but other agencies such as Police Scotland, Scottish Ambulance Service and Emergency Departments, for example, have been more challenging in terms of reaching those at the front line who would make referrals, which has had an impact on referral numbers from these sources.

5.7 Rating of the service

Rating of both the IH and OOH services were very positive. People who use the service, staff and referrers were asked if they could give a 'mark out of 10', where 0 is low and 10 is high. The mean responses are shown in the figure below but all are high, ranging from a mean of 8.3 for CDRS staff to 9.38 for referrers and 9.44 for people using the service. Means were also calculated for each service and were very similar: 9.1 for OOH and 9.2 for IH.

The range of scores given was also quite narrow, with one person awarding the lowest score of "7 or 8" (which was taken as 7.5 to calculate the mean) and highest score of 10, which was given by 18 out of 45 stakeholders (40% of the total and 60% of GPs) who were able to give a score. Three stakeholders gave initial score higher than 10 to illustrate their views on the service: 11, 12 and 20 (a 10 was used to calculate the mean).

Figure 9: 'Marks out of 10' awarded to CDRS by various stakeholders



This was supported by the various spontaneous comments made about the CDRS team and service, often without prompting, such as:

OOH service

"9, although I don't know what else they could have done for me. We had a good rapport but it would have been nice to have support for longer. I'd use it again if I needed to." Person who engaged with CDRS

"It's exemplary, I can't fault it 10/10. The staff are exceptionally professional and very motivated to help." OOH referrer, MHAU

"9. There's nothing I'm unhappy about but I never give a 10." OOH referrer, MHAU

"9 or 10, it's very very good. I find it really helpful, we're often on the phone. Patients don't always have psychiatric distress so we can't refer them to the crisis mental health team. Before CDRS we had to get them to think about safety and speak to the GP in the morning so it's great to refer to CDRS now." OOH referrer, MHAU

"20 out of 10! I've never had a bad experience, they're always really accommodating and patients are very positive, it's a good service for them. It also takes a lot off us. We can get frequent callers and if we refer to CDRS we don't get

those calls every night because they're being supported so it takes the pressure off for a bit. Nothing is ever an issue, they're dead nice." OOH referrer, MHAU

"9 and a half or 10… they deserve a 10." OOH referrer, MHAU

IH service

"9. Not a 10 because I would have preferred it for longer. I really rated the support I got, I just wanted more." Person who engaged with CDRS

"10! We send patients so often and have never had an adverse referral. I've had no issues at all, they let us know if they can't contact the patient. They're wonderful." IH referrer

"8 and a half, no, 9 because they're very professional, very effective and do what they say they will so we get great feedback [from patients]." IH referrer

"8 out of 10. They're fantastic and they keep you in the loop, but people can't phone in and it could maybe be a touch longer. Three contacts is usual, some have 5 or 6. People worry if it comes up as an unknown number and if they miss them, they can't phone back so they call me instead." IH referrer

"8, because it is a very quick response and they do tune into the patient's distress. They get to the core and show them the way out of this. I know it's not long term, but they do help." IH referrer

"Patients who engage [with CDRS] have very good things to say about it. The only issue I have with it is I'd like to keep it going!" IH referrer, GP

"9 or 10 out of 10, nothing is perfect…but it works for me and my patients." IH referrer, GP

"10 for the speed of contact - and I know they will contact - and the time and skill to speak to people." IH referrer, GP

"They're doing well. It does what is says on the tin, it's a very quick contact and most benefit." IH referrer, GP

"10/10, I think they're brilliant." IH referrer, GP

"There's minimal bounce back from CDRS. They take whoever we send …and give them support, not letters, unlike other services where the patient feels the service doesn't care and they feel rejected." IH referrer, GP

"Patients may not have a specific condition or mental health diagnosis but if they had not been supported they could have developed one, so CDRS helps them to manage their mental health [in a preventative way]. It's completely helpful for the patient." IH referrer, GP

"It has filled the gap. GPs don't have time to provide the support patients need and Link Workers were never set up to support acute distress, although it depends on the Link Worker and how much mental health background they have." IH referrer, GP

5.8 Confidence in compassionate listening/the service

People who use and refer to CDRS were both complimentary about the service provided to them and considered that *"it does what it says on the tin"*, i.e. it responds to people who are in distress in a very compassionate way and delivers a service to them. GPs and CLWs were in a good position to report back what their patients had said about it and most said that they believed it was a listening service with a compassionate approach, which was very much appreciated by patients. Those in other roles, such as the MHAU do also sometimes see the same people, despite not carrying a case load in the same way, and they reported patients giving positive feedback too.

> *"Yeah, she was wonderful. I felt listened to and she was compassionate. I didn't feel judged either."* Person who engaged with CDRS

> *"It really helped to have someone just listening, not telling you how you should be or feel or what you should do."* Person who engaged with CDRS

> *"I would definitely say that her compassion and kindness was wonderful. It validated that what was happening to me was nothing to be ashamed of."* Person who engaged with CDRS

> *"10 out of 10, I only have good things to say, it's always been positive. Even though I know it's going to be upsetting and tough, it's exactly what I needed. I was really unwell but this gave me the time and space to talk about what I needed to talk about."* Person who engaged with CDRS

Referrers from the MHAU were very robust in their support of OOH CDRS and clearly have confidence in the work that the team do.

> *"Absolutely, 100%. I wouldn't keep referring people otherwise. The team are very thoughtful, considered, helpful and knowledgeable as well as compassionate and ask what the person wants them to do."* OOH referrer, MHAU

> *"I feel very confident referring in to the CDRS because they're compassionate, know what they're doing and they support people really well. I can't think of anyone who has had a bad experience."* OOH referrer, MHAU

> *"I can refer to CDRS with confidence. I know they'll do a good job. They have lots of life experience, they're superb. They have a really calm and compassionate manner and that is what people need."* OOH referrer, MHAU

Similarly, GPs and other primary care referrers made it clear that they rated the IH team highly and had confidence that patients would be well supported, in the manner intended.

> *"Yes, they are very well supported by the CDRS team. The majority [of referrals] are emotional issues, a lot of relationship issues and bereavement so they don't need psychological input or assessment. The real benefit comes from being listened to by someone who cares. It helps them process their emotions in their time of crisis. CDRS has the time to do it so I refer to them first then I'll follow up later. I don't have time to deliver a service like that, to be a compassionate ear and de-escalate. They need time to do that."* IH referrer

> *"I feel confident referring on [to CDRS], that it can help."* IH referrer

> *"I'm thinking of one patient in particular it worked really well with. They accepted where they were at and felt listened to, but not in a judgemental way."* IH referrer

> *"It's a safe space for someone to listen. GPs don't have the time, training or experience."* IH referrer, GP

5.9 What's working well

There was a sense that the CDRS is doing what it set out to do and doing it well. The staff were rated very highly by referrers and people who used the service, as people with the right skills to engage with people in a distressed state. They were also rated highly for communications with referrers and their partnership approach. That is not to say that the service is perfect, but it was perceived very positively. The challenges and distinctive qualities are explored in the following sections.

> *"She listened very closely to what I had to say. I had palpitations and wasn't able to breathe so she immediately addressed what was important."* Person engaging with CDRS

> *"CDRS has a fantastic team and [manager] is an amazing person and manager. I have huge respect for her."* Stakeholder

> *"They're very good at finding out the likes and dislikes of patients, for example if they're a big football fan and link that up with what they're talking about. It's very good. They can chat and build a therapeutic relationship. The tools they give people are very useful in preventing crisis again too."* OOH referrer, MHAU

> *"I love CDRS, the staff are brilliant. I've never heard a bad thing about them. People are grateful, even if they're trying to get admitted once I explain what it is they're often happy, or when they're waiting for CMHT. People often need that extra bit of support at night and they feel better, the relief of offloading."* OOH referrer, MHAU

> *"It's a wonderful service: great communication, a good understanding of needs and what is or isn't appropriate. It's a life saver for the patient… and it's helped me greatly." IH referrer, GP*

> *"They will see people face to face if need be too, which is great. They take people as individuals and see what they need."* IH referrer

> *"I refer to CDRS, they support the patient and let me know what they've done when they've finished and then they come back to me to look at the other things they need help with."* IH referrer

5.10 Challenges/sticking points

5.10.1 Complexity of cases

The degree of distress and complexity of issues individuals are facing, has been more significant than anticipated, particularly in the OOH service. Individuals may be experiencing distress from current issues like personal relationships, bereavement/loss, debts or other life stressors, or this can also relate to more long-standing issues around childhood abuse. The issues have included childhood abuse, sexual abuse, domestic abuse, bereavement, substance abuse as a coping mechanism for traumas experienced, emotionally unregulated personality disorder (EUPD), impulsive and deliberate overdoses and a lot of suicidal ideation and self-harming behaviours, particularly in the out of hours service when these feelings can be very raw as they are spoken to within an hour of referral. They may just have been discharged by MHAU – and answered a lot of questions in a clinical assessment – by Police from a bridge/the river or having taken an overdose, for example.

Staff reported that more issues are often revealed as discussions continue, once rapport has been built, even that suicidal ideation is more advanced than first claimed, with plans in place. The number of issues causing distress which people are presenting with is detailed in the previous

section. This has meant more and longer calls, and longer involvement for some individuals than expected when designing the service. As one stakeholder put it:

> *"CDRS picks up the people no one else wants."* Stakeholder

But this also illustrates why referrers are so pleased that the CDRS is providing a service. Whilst these individuals do not need a clinical service, they do need something and without CDRS referrers felt they had no other service to refer them to and they could not provide support themselves. This can obviously be challenging for the CDRS team to support, however, and some harrowing cases involving serious issues, including serious criminal justice issues, have been recorded. Staff do have supervision and support from colleagues, their manager and an external professional but the frequency and complexity of issues which arise suggest that the frequency and nature of supervision could perhaps benefit from greater investment.

5.10.2 Profile of people seeking support

The profile of individuals using the service was also different to that expected, particularly as professions which support others – those working in healthcare, mental health services, Police, etc. – have been well represented and their distress must have an impact on these individuals' abilities to support others at work.

5.10.3 Impact of Covid-19

The Covid 19 pandemic and restrictions around face to face meetings has impacted on the way in which the services have been delivered. Whilst both in hours and out of hours services have provided a face to face service for some individuals where preferred and appropriate, the vast majority have been via phone. This is contrary to the original plan, as outlined earlier, but there has been some movement to shift this balance in recent months, including limited outreach work.

5.10.4 Silo services v integration

GAMH has developed and is delivering three different distress response services: out of hours, in hours and the young person's service. They share the same approach, but all vary slightly because of their different referral pathways, times of operation and/or target group. Each of these services is funded differently, and this may have prompted at least in part the degree of separation between services.

However, there are definite pros and cons to a more siloed versus a more integrated approach for staff, people being supported and those referring to the service. For example, having different telephone numbers and different times of operation which don't match referring organisations have been cited by stakeholders. The different response times – within an hour for OOH and within 24 hours for IH – was also highlighted by some stakeholders. Given that the service has tended to make contact initially to explain what the service is and isn't, clarify if someone wishes to engage or not and then make an appointment for the first 'proper' discussion, it may be that the target times to respond could shift. For example, it could be that this 'triage' type call could be made on the day of referral, say within two hours of referral perhaps with a cut off time for the end of the service where others may be called the next day.

5.10.5 Making contact & scheduling calls

As the previous section shows, it can take perseverance to make contact with those referred and even after half a dozen calls some may not respond at all. Community Links Workers also highlighted the fact that they can experience challenges contacting patients who have been referred to them and/or CDRS. If they are not responding to contact by CDRS, the team will let the referrer know and they will usually attempt to contact them. This works for some patients, but others are more challenging to engage with so these are then not re-referred to CDRS. Both GPs and CLWs appreciate knowing whether patients have engaged or not as often they do not receive this kind of feedback from other services, which is unhelpful. Particularly where patients are more

challenging to engage, CLWs highlighted the benefits of sharing the CDRS care plan so that they can reinforce it during their own discussions with patients.

A related point which staff raised was about scheduling calls. This had two different aspects. Firstly, that there is no way of knowing what referrals are going to come in, but they already have scheduled calls with people they are supporting. This is a particular issue for the OOH service, as first contact is targeted to be made within the hour. One discussion reported ten referrals made within the first hour the previous week, which was stressful to action alongside existing commitments (which can be 17-25 calls per shift). Secondly, the team do not wish to *"rush people off"* the phone and calls can be over an hour, which presents obvious challenges for meeting the deadline with new referrals. On the flip side, they could have several people to call in a certain space of time and not manage to reach any of them.

5.10.6 Managing expectations and setting boundaries

As with any new service, different people will have their own interpretations of what it is or is not. CDRS management and Co-ordinators, plus Steering Group members, spent time with potential referrers at the start of the service to help clarify what it would and would not do. This, along with feedback to referrers, helped to maintain largely appropriate referrals to each service.

It also became apparent that people referred to the service would have been told different things and may not have taken in all the relevant information if they were in distress, so processes adapted to make sure that this was clarified at the start before they consented to further engagement. It was particularly important to ensure that people knew it was not counselling and was a short-term service. Clear boundaries for staff, referrers and those who were referred were considered to be key, particularly as all would be investing in the process.

5.10.7 Exiting

People can become attached or come to rely on CDRS so they do not want the service to end. The CDRS team manage this by being clear how it will work at the start and introduce stopping the service with the aim of managing that process at least a week before contact is due to stop. However, some people can find that too challenging, and stop taking calls so they don't have to say goodbye. It would obviously be better to have a controlled exit and complete the support, but that is of course up to the individual. This can be complicated by more complex presentations, many of whom have been given diagnoses of personality disorders such as Emotionally Unstable Personality Disorder (EUPD), but the team work together and with other services to manage this productively for all concerned.

> *"I wanted more, for it to go on longer. It's difficult to let a person like that go. She took me off the cliff then it was left to me."* Person who engaged with CDRS

> *"I just want to keep coming, I'm not looking forward to stopping and doing it on my own but I'm not in active distress any more."* Person who engaged with CDRS

> *"I feel very lonely but CDRS helped me. I missed the last two calls, I was really gutted. I didn't want it to stop."* Person who engaged with CDRS

5.10.8 CDRS database

The CDRS database was created at the start of the project according to the anticipated needs at that time. However, as is often the case, there is now perceived room for improvement as it can be frustrating. There are a few elements to this.

One is about the database being able to be easily accessed to tell the story of the support provided to people in distress and the impacts on those engaging. At present, it takes some time to pull data off for reports and there may be an easier way to do this. It is helpful to have qualitative data to log progress as the case progresses but meaningful quantitative data is required to give quick, consistent profile information for reporting purposes.

Another is about the coding categories for different fields. Whilst there are a considerable number of codes for some, e.g. presenting issues, in some ways they raise more questions than answers as they are quite generalised. For example, abuse obviously covers a wide range of possible situations and can be current, recent or historic. Stress and anxiety are bundled together but are different and anxiety could also have sub-categories to be more useful. Personality disorders are presenting, so more detail around these would be helpful. Differentiating between depression and low mood would also be helpful, as would more detail on ACEs and bereavement. Bereavement of a grandparent from natural causes is very different from losing a child or losing a loved one to murder or suicide. This suggests that some top level codes may be helpful, with sub-categories as appropriate, provided this can easily provide the analysis required.

There was also some comment on ease of navigation. For example, it was suggested that it can be difficult to navigate and find out if someone has been referred before (particularly if to another service) and risk information could also be organised better to ensure key information is not missed.

5.11 Communications and partnership working

CDRS was rated very positively for their collaborative approach to partnership working and communications. This related to management and staff within both OOH and IH teams.

> *"We have good communications with CDRS and a close working relationship with them. If we phone, they respond. It's a wonderful service."* IH referrer
>
> *"CDRS works collaboratively with the Links Worker."* IH referrer, GP
>
> *"All the [CDRS] staff are really nice to talk to and they remember you. I feel we've built a good working relationship and they do what they say they're going to do."* IH referrer
>
> *"Any interactions with Rena and the team have been great, which is not the case with all services! I have no complaints about joint working, it's a huge bonus."* Stakeholder
>
> *"The relationship between MHAU and CDRS is very positive and they work well together. They understand crisis. They're not part of the NHS but they are part of the whole unscheduled care pathway… I don't know what we would do without CDRS. If it was not there, there would be a gap. CMHT wouldn't be quick!"* OOH referrer, MHAU
>
> *"CDRS is very good at referring to MHAU too, they make very appropriate referrals. The staff are very skilled and know when there is a mental health need."* OOH referrer, MHAU

Part of good partnership working is clear and appropriate communications. The OOH team seem to work very closely with the MHAU teams, with both often discussing referrals or seeking advice by phone. Some OOH referrers may wish to know if a referral is safe and well, but they tend not to carry a case load so would not ordinarily receive feedback on referrals. However, primary care has an ongoing relationship with patients they refer. The IH team has always notified referrers if the individual has not engaged after several attempt, so that they can check in with them and re-refer if appropriate. However, it has also piloted feedback to primary care referrers on the tools used, referrals or signposting suggestions, etc., which has been received very positively. The only suggestion made was that it could be a bit more detailed, but any feedback was perceived positively as some other services do not provide any at all, even whether they have engaged or not.

"I get feedback now, which is wonderful. Really helpful. It's good to know if the patient has engaged, what they did, the care plan put in place and so on." IH referrer

"It's good to know if a patient has engaged or not, and what helped them so we can reinforce that. With a lot of services we don't know whether they even engaged, what helped or didn't help but CDRS does and that is really useful information to have." IH referrer

"Feedback is important, and helpful. By the time the case is closed with CDRS the patient is settling down and the acute phase is finished, the crisis has tided over or other services start taking over." IH referrer, GP

"I can get feedback if I want but our type of work is very 'here and now' so there's no need for it clinically without further contact but I could ask if wanted to know how someone was." OOH referrer, MHAU

"I don't want a lot of feedback, I just want to know that they've picked it up really. CMHT and Crisis don't give any updates on patients." OOH referrer, MHAU

5.12 Perceptions about CDRS being a Third Sector provider

GAMH is a Third Sector organisation but all of its referring agencies are statutory sector service providers so they were asked if this was an issue for them, either positively or negatively.

Not all referrers had known that GAMH was a Third Sector organisation before the discussion – clearly, many had not given it any consideration at all - but the majority considered this to be a positive or of no significant difference for them or people using the service. Whilst there may have been initial concerns around sharing information, for example, it was assumed that there would be appropriate protocols in place to facilitate this as required so it was now a 'non issue'.

GAMH was perceived to be a trusted, professional organisation, with a strong reputation. GAMH's core business is supporting people's mental wellbeing and recovery, empowering people to develop coping strategies via a holistic approach. The CDRS was therefore a shift from mental health to distress, but their mental health background – the range of services they already provided, the resources they had and knowledge of other services to signpost people towards - was a point of reassurance for both referrers and people using the service. GAMH is one of the few Third Sector organisations operating within this very clinical landscape.

"There's more flex from a Third Sector organisation if there are mental health issues, it's not such as stigma perhaps as statutory mental health services might be. The ethos and values of the Third Sector are very strong too. Whilst there should be no wrong door and a compassionate response wherever people go, statutory services may present more barriers for some people. To be honest, though, a lot of people don't know the difference. Third Sector might be quicker and less process driven or regimented compared to statutory services, so there might not be so many hurdles or a 'you're not bad enough' approach." IH referrer

"The service was clear, or at least clarified once we started referring, but it wasn't entirely clear that it was provided by a Third Sector organisation. I thought it was part of mental health services. It makes no difference, I just hadn't picked up on it." IH referrer, GP

"It's an advantage being Third Sector. GAMH has a good name in Glasgow too. It's a softer, more gentle approach although a lot of people just want to be admitted [to a psychiatric ward]. CDRS is very pleasant, our job is more unpleasant and we have complex relationships with folk because we have to say no." OOH referrer, MHAU

Being located in the Third Sector was perceived to be beneficial as it was perceived to help the CDRS team to know what organisations operate in different localities and may be able to assist people in a variety of different ways, according to need. It may also be less associated with a mental health diagnosis, which may be helpful with some people who are referred.

> *"The Third Sector is good because of links with other Third Sector organisations, which is great for signposting. They're more in tune with the sector. The NHS is under-funded and strapped so the Third Sector supports it well."* OOH referrer, MHAU

> *"It makes no difference, they're still professional and very helpful, easy to engage and know what they do. It's more accessible at a community level and is not seen as a mental health diagnosis."* IH referrer, GP

Those using the service were also asked their views on this. Obviously this was with those who had engaged with CDRS so it presumably had not been a sufficient issue for them not to do so, but all were either positive that GAMH is a Third Sector organisation – and felt this might be the case for others who had perhaps had a less positive experience with public sector provision – or were neutral on who provided the service, the way in which it was provided was the most important factor for them.

5.13 Where CDRS fits in the wider landscape and how it compares

The psychological distress/mental health support landscape has changed significantly in the last couple of years, in planned developments or as a result of the Covid-19 pandemic. The research sought to explore if this more cluttered or potentially confusing landscape was an issue for stakeholders and had any impact on referrals.

Some stakeholders were very clear on the differences between the different services offered by Consultant Connect, MHAU, CMHT, PCMHT, DBI, Lifelink, Samaritans and Breathing Space, for example, and how these related to CDRS. Referral pathways were clear for these stakeholders, although the criteria for referral and why some were accepted or refused was not always clear, particularly in relation to CMHT and PCMHT.

Others, however, were not aware of some other services. For example, many OOH and IH referrers were not aware that DBI could be accessed in Glasgow, or for some what DBI entailed. There was very little familiarity with the Glasgow DBI even from those who were aware of it and/or had referred to other DBIs (Inverclyde was the one most-cited by MHAU staff).

GAMH sees CDRS as being distinct from DBI as it is so embedded in the Glasgow landscape – knowing where to signpost individuals as required - and the close working relationship it has developed with the MHAUs and other partners. Few referrers were able to comment on the DBI approach and how it compared to CDRS as most referrers had a pathway for CDRS and not DBI. However, MHAU staff did comment that they were required to complete a LearnPro module in order to refer to DBI and felt it was quite a complicated referral process (for Inverclyde) in comparison to CDRS and First Crisis (Renfrewshire). Scottish Ambulance Service and Police Scotland also highlighted the need for Level 1 DBI training as a barrier to using DBI (in terms of costs, time and impact on capacity), which made referral to CDRS a more attractive (expedient and immediate) option for them.

> *"I could have referred to the SAMH DBI but I've not even considered it. That shows how good CDRS is."* OOH referrer, MHAU

A few referrers commented on the degree to which statutory mental health services seemed to constrict during the pandemic and were less visible or accessible to people who were more likely to need them. There was hope that this would reverse now.

> *"I hope now the pandemic is more behind us that mental health services open up more for people and become more freely available in communities, not hidden.*

They feel hidden. If we can share resources in a kind of mental health one stop shop that would be better." IH referrer

Referrers also expressed frustration with referrals bouncing back from CMHT and PCMHT in particular.

"I don't use Primary Care Mental Health Teams, there's no point." IH referrer, GP

"We rely on Lifelink, COPE etc. We can refer to the Primary Care Mental Health Team but we do get some very complex referrals with lots of agencies involved already. There seems to be an 'invisible barrier' to CMHT as patients are referred but come back to us to deal with. We don't know why. There should be a plan, which they share with us so we can work together but that doesn't happen." IH referrer

This was not perceived to be an issue with CDRS:

"There's a lot of push back from other services because they're so busy, it's refreshing not to have that with CDRS." IH referrer, GP

There were a few negative comments about statutory mental health services and the degree to which they can be overly bureaucratic, with many detailed questions for both referred (which can be exhausting when distressed) and referrers:

"The approach her is much better than the NHS which is very formal, clinical and regimented. It feels like box ticking. You wait ages for an appointment then you can be out the door in 20 minutes." Person who engaged with CDRS

"I'm not here to be cross examined. If I feel that then a less experienced or bolshie GP will be put off and vulnerable patients would be put off. {Primary Care] has quite a history with mental health services cross-examining people and we don't want to submit patients to that." IH referrer, GP

Telephone based listening services like Samaritans and Breathing Space were seen to have a role to play but a couple of referrers highlighted that it can be a barrier for someone to have to take that first step to make a call, in contrast to CDRS making the first approach (albeit that there were issues around the number being withheld, which has now changed). Signposting and the continuity of contact with the same staff members at CDRS were also highlighted as additional benefits over other telephone based helplines.

"There are other services people can phone but people won't use them unless they know what the service offers. Samaritans is a listening service only and they don't direct people to services, whereas CDRS signposts." OOH referrer

The waiting lists and non-acceptance of referrals were key issues for many referrers, and those referred. There are many different services on offer, but CDRS was seen to be distinctively different and to hit the spot for people in distress and those who refer them.

"It definitely helps them [patients} when they're waiting for other services. There's been a bit of a pattern lately where I refer to CDRS for a quick response and Lifelink or Wellbeing Scotland on the same day as they have to wait for those. I tend to use Third Sector providers as the staff in statutory services are often burnt out or not qualified." IH referrer

"Mental health services have been inundated with referrals and when you tell patients about the likely wait… I referred to Wellbeing Scotland six months ago and they've still had no contact from them." IH referrer

People who were supported by CDRS were also asked if they had accessed other services and how CDRS compared. Some had quite extensive experience of mental health services, whilst others did not. If the person had experienced other services, CDRS compared positively.

> *"I've had counselling before. It's the listening part that's different I think. Counsellors do that too but it's different. I don't know how to describe it, it's just good. I felt better speaking to her."* Person who engaged with CDRS

5.14 USP

All stakeholders were asked what, if anything, they perceived to be a 'USP' - unique, distinctive and/or attractive quality - of the Compassionate Distress Response Service. The vast majority of those who gave their views felt that CDRS is unique or distinctive from other services in at least one way.

5.14.1 Speed of response

The speed of response by CDRS was the most commonly-cited distinctive quality and seen to be a huge selling point for the service.

> *"I called my GP in distress and got a call the same day, it was incredible. Nothing ever feels quick enough when you're in distress but that was more than acceptable."* Person engaging with CDRS

> *"It's a really speedy response, which is pretty unique. There's only A&E or the crisis number but CDRS is a very personal take. I can see what they're trying to do, get you out of distress quickly."* Person who engaged with CDRS

> *"It is more distinct. The way they work is very different to the Community Mental Health Team with waiting lists, staffing and resource issues. I know I can call CDRS and get a very prompt response. You can't compare it with CMHT. It's a life saver for patients."* IH referrer

> *"I think because they contact them that day. The crisis team would see people that day but you can only refer them if their life is at risk. With CDRS you know they will contact them at some point that day so you know it's safe [to leave it in their hands]."* IH referrer

> *"Lifelink has a 5 weeks plus waiting list - it used to be one week - and Wellbeing Scotland is over three months but CDRS speak to them the same day."* IH referrer

> *"They are unique at the moment to have such a quick response. There's nowhere else giving that level of intervention so quickly."* IH referrer

> *"They're unique because it's such a short, sharp input, not longer-term and it's very good and responsive. They signpost people and email them information or videos to help them relax, etc., so it's an instant fix. They're very good."* IH referrer

> *"The real benefit is quick access. Other services like Lifelink are good but not if you need it NOW. If they can wait eight weeks for Lifelink I don't refer to CDRS, I'm cautious not to overwhelm them. The immediacy of response is pretty unique and the lack of barriers if patients are involved with other services is really helpful."* IH referrer, GP

> *"It is pretty unique. I don't know anywhere else helping people like this and certainly not so quickly."* IH referrer, GP

> *"What sets CDRS apart is its accessibility at the point or time of need. I can tell patients they will call in a couple of days which is very measurable for the person.*

Other services take much longer, I don't know so they don't know when they will get an appointment." IH referrer, GP

"I think they are unique. You can phone the duty CPN if you have concerns that someone is suicidal and they will assess them that day but they do their damnedest to push them back to me. Nothing else gets picked up so quickly. They are one of a kind." IH referrer, GP

"Waiting times have worsened, e.g. Lifelink receives PCIP funding but still has a 2 month waiting list for services. The fact that CDRS will see people on the same day is excellent and really important. It takes the problem off our hands." IH referrer, GP

"It's the gold standard - immediate support." Stakeholder

"The immediacy of contact is very useful. I can phone at 5pm and discharge the patient and know they will be contacted that evening so it's very safe for the patient. During covid especially people felt very abandoned and isolated." OOH referrer

"No other service picks people up as quickly, it is unique and very good. It picks them up right away, it is an immediate response. They fit people in no matter how busy they are, even if it's just a short contact." OOH referrer MHAU

"It's easy access and second to none. The relationships are pretty special and the pathways work both ways. The fact that it is an immediate process makes them stand out." OOH referrer, MHAU

"They respond immediately and give compassion to people in distress." OOH referrer, MHAU

5.14.2 Attitude towards referrals

The fact that the CDRS teams, both in and out of hours, welcome referrals - rather than discourage them - was also considered to be a breath of fresh air, particularly in contrast to clinical mental health services.

"CDRS is always so happy to accept referrals. Most other services put a lot of effort into NOT taking a case!" OOH referrer, MHAU

5.14.3 Amount of contact

The amount of contact was also cited as a USP. Patients had reported daily contact in the first week then reducing frequency, which some other services will do as a text (fine for young people) but the more personal connection of a phone call was appreciated as a distinctive quality of CDRS.

"The fact that it is immediate support and they can regularly make contact, it's not just a one-off. For a lot of other services the patient has to make contact but it can be hard to pick up the phone and call so it's good that CDRS calls the patient so that isn't a barrier." OOH referrer, MHAU

The time given to people and support for them to process their emotions was perceived to be a key differentiator:

"The opportunity for people to feel valued and to have time to express their feelings, have someone listen and the opportunity for them to process things themselves and look at things in a different way… TIME is needed to deal with emotions." IH referrer

5.14.4 Continuity of support

The continuity of support from one or two CDRS staff members was also seen to be beneficial over other phone listening services such as Breathing Space, as people did not have to repeat their story and this enabled relationships to be built, to develop greater trust and move discussions forward. This was particularly appreciated by people who had used the service.

> *"It was the same person from the start and that made it so much easier. She was super supportive and it was very easy. I'd recommend it to anyone who needs it."* Person who engaged with CDRS

5.14.5 Person-centred approach

CDRS was perceived to be distinctive for its down to earth, person-centred approach.

> *"It was all led by me, what I wanted to talk about and what I wanted to focus on. I didn't have to talk about anything I didn't want to. That made me feel a lot safer. It was exactly what I needed, when I needed it."* Person who engaged with CDRS

> *"It's the first mental health service centred on me at the core of it. It's not like that in the Crisis team, they have standard protocols and there's no deviation from those."* Person who engaged with CDRS

> *"…compassionate and empathetic, with an absolute desire to help. They see people and hear people, which is different in the arena they are working in - most mental health services are not like that. The clinical approach looks at people in a particular way, it's all about the diagnosis not the person. It's (CDRS) non-clinical but provides real care and that's why it will work and what is needed".* Stakeholder

> *"There's nothing equivalent, they're doing well. It's usually an emotional reaction not a mental health issue. It's great that they teach [patients] how to deal with things that happen… It's normal to feel sad at death and things that happen in the news but people seem to think otherwise."* IH referrer, GP

5.14.6 Lack of conditionality for access to the service

The fact that OOH is not limited to residents of Glasgow but those in Glasgow when in crisis was perceived to be removing a potential barrier, taking an inclusive approach and facilitating support to be provided to people when and where they needed it. The lack of conditionality for accessing either IH or OOH CDRS was perceived very positively by referrers and people who used the service.

5.14.7 Use of alcohol or drugs is not a barrier to support

The fact that CDRS will take referrals from people who have taken alcohol or drugs was also rated very positively by referrers and also seen to be a point of distinction. Several highlighted the frustration of PCMHTs and CMHTs not accepting people who are under the influence of either alcohol or drugs, and alcohol or drugs support not being available to people with mental health issues so people experiencing both (which often co-exist) cannot access all the support they need.

CDRS takes a pragmatic approach to this, accepting that people who are heavy users of alcohol and/or drugs need to have consumed a certain amount in order to function and would discuss this with people seeking support, who would then aim to restrict consumption to a 'ticking over' amount in order to engage. This may not have worked out every intended contact, but people appreciated the frank discussion.

5.14.8 Knowledge of community based services

The knowledge of CDRS team members of community based services which might assist people was also praised as a distinctive aspect of the service provided. For example, linking older people who are isolated into local services where they can increase their social contact and lift their mood was noted by a few primary care referrers.

5.14.9 Requested by patients

A couple of referrers also noted that people had requested a referral to CDRS as they had been supported by them on a previous occasion.

> *"Patients ask for CDRS. People don't ask for DBI or First Crisis but they do ask for CDRS."* OOH referrer, MHAU

5.15 Suggestions for improvement or areas for development

5.15.1 It's going well

All stakeholders were asked if they had any suggestions for improvement of CDRS or areas for future development. A number of stakeholders felt they had no suggestions to make for improvement as it works well at present.

> *"Nothing for me. The staff are great, they always know how best to support people, you can't ask for more than that. The feedback is really positive from patients too."* OOH referrer, MHAU

> *"Other services need reformed more, CDRS is very good as it is."* OOH referrer, MHAU

> *"Nothing else. I feel confident when I refer that they will get in touch quickly and help the patients as they engage well and communicate well. They sound good at the job."* IH referrer, CLW

> *"We just need more of them! [so more people can benefit]"* IH referrer

> *"No, it works okay just now."* IH referrer

However, a variety of suggestions were made when stakeholders were asked to think about it and these are noted below.

5.15.2 Increasing face to face contact

More ad hoc/drop-in face to face contact for people in distress was also suggested as a way to improve access to support for people when they needed it. This builds on the original idea for a drop in café, as is successfully run in Aldershot, and CDRS's original aim to have more face to face contact with people to utilise its centrally located, *"soothing"* and welcoming space. This could be delivered via CDRS or could be a distinct service, run by GAMH or others, as appropriate. A drop-in/café type service could provide a pathway into CDRS or out of it, as a more gentle 'exit' route.

> *"Services had to adapt during the pandemic to deliver in a virtual way. As OOH moves on there is a real need for face to face, drop-in support which can be immediately available for handover of someone from MHAU or other services."* OOH referrer, MHAU

Dedicated space for face to face contact is in demand within GAMH during the day, however, so this would need to be managed carefully alongside other GAMH services. Scheduled face to face discussions are easier to manage than drop in capacity during the day at present. People who did

have face to face sessions at GAMH enjoyed doing so, whether they were in the office or went for a walk on Glasgow Green. Some felt they got much more from the service on this basis and they would have been much less comfortable speaking on the phone.

5.15.3 Self-referral

The issue of self-referral was raised in relation to both OOH and IH services. It was suggested that this could cut workload for MHAUs/other OOH referrers and GPs and their teams and provide a quicker route to support for people in distress. However, it was also recognised that this may make it harder for CDRS to manage its workload, particularly in terms of balancing new and existing cases.

> *"It would be good if the patient could self-refer and it's a negative if they can't because it takes me more time."* IH referrer, GP

> *"Self-referral would help, even if it's just some patients who are able to self-refer, especially if they're known to the service."* IH referrer, GP

> *"I can see both sides of self-referral. I would like it if patients could self-refer if they'd been seen before, especially as there are no barriers to the services but I don't want [CDRS] to be overwhelmed or have capacity issues."* IH referrer, GP

5.15.4 Withheld number

Related to this point was the issue of CDRS using a 'No caller ID' or withheld telephone number. At the time of interview and/or referral, this was the case and was perceived to be a barrier to people answering the phone because many patients' circumstances mean that they are afraid or reluctant to answer anonymous calls so would usually see who it is then return the call. However, they are not able to return a call in this way or if they were unavailable when called (which could be for very genuine reasons).

> *"I won't answer a No Caller ID call. Not with everything that's gone on. The Police use that as well. It's not helpful."* Person who engaged with CDRS

> *"They usually call from a withheld number and that puts some people off but I do warn them about it."* IH referrer

It is understood that this has now been partially rectified so the number is identifiable as being CDRS, although it is still not possible for people to call the service themselves. It was also suggested that text and/or WhatsApp could be used successfully to make an initial contact.

5.15.5 Onward referral

Primary care staff also raised the issue that CDRS does not refer to services but passes that task back to them. They would like to see CDRS, as professionals who understand what kind of support the individual needs, referring to services directly *"to save push back to GPs"*.

> *"I wish they would refer to anything they feel is appropriate. Maybe it's unrealistic for them to refer into some services, but they could refer into the same ones as us. Maybe they do make referrals and I'm not aware of it, but if they don't that would be helpful."* IH referrer

> *"There are a lot of different services relating to mental health which has been an issue [in terms of referrals]. A one door policy, a 'no wrong door' policy would be good. Once they get over their immediate distress patients can be more willing to engage in talking therapies so CDRS could refer them to longer term talking therapies rather than coming back to us."* IH referrer, GP

"Definitely want it to continue. Same day or quicker response and onward referral if the patient is okay to engage would make it even better." IH referrer, GP

5.15.6 'Holding' people until services are available

A few in hours referrers also suggested that CDRS could 'hold' people and keep supporting them until the service they had been referred to, such as Sandyford or Moira Anderson Foundation, were able to see them. It is understood that CDRS has continued to support some individuals in particular distress until they were able to access other services, when asked by referrers, but this has been on a relatively short term basis (albeit longer than their usual contact). However, some specialist services such as Sandyford have extensive waiting lists (reportedly around two years) so this would clearly not be feasible as CDRS is not a counselling or therapeutic service per se.

5.15.7 More integrated care pathways

CDRS is already perceived to be a critical part of the health and wellbeing landscape in the city. Stakeholders were keen to see this more fully embedded and integrated with other services because the service is performing such a necessary role to a high standard. This emerged in three distinct ways: looking at how CDRS and MHAUs could work more closely together, hoping that CDRS would be a core part of the new hubs and considering future sustainability of CDRS as stakeholders do not want to lose the service.

CDRS and MHAUs

It was noted that CDRS is the only Third Sector organisation to have access to MHAU services, which illustrates the position of trust in which they are held and this is something to build upon further. Having one point of access was perceived to be *"easiest for everyone".* It was proposed that if CDRS worked more closely alongside the MHAUs, they would strengthen their position with direct referrals. If they were co-located or found a way to work more closely, it was suggested that would be helpful. There was perceived to be a need for both approaches and CDRS/MHAUs have a similar ethos which helps them to work well together.

The MHAUs do not have space for CDRS to be fully co-located with them at present, but there was interest in that happening to some degree, for example a member of CDRS staff based in the MHAU to take immediate referrals (and perhaps to help move Police and Ambulance referrals to go directly to CDRS). This would perhaps help overcome the many attempts before a referred individual is sometimes contacted, if a CDRS staff member had already met them and outlined the service without the person having to repeat their story.

MHAUs already have CAMHS and Addictions outreach workers based with them and they were soon to have Social Workers based with them too. CDRS was perceived to sit well alongside each of these specialties, which would help to offer 'something for everyone' at an OOH one stop shop. If a GAMH outreach worker was to be based at MHAUs, the team would need to grow to accommodate that, as service delivery and safety in the office at night would be compromised otherwise. If MHAUs keep growing, they may also need bigger and/or purpose built premises.

CDRS and the new hubs

Stakeholders were keen to see CDRS integrated within the new hubs which are currently in development. The plan is for three pilot areas to be operational from early 2023 as a 'one stop shop' for children, adults and older people. It is hoped that these will involve both statutory services and the Third Sector, so could involve organisations like Lifelink and CDRS. This was perceived to ease the headache for GPs of where to refer as patients will be assessed and directed to the most appropriate service.

"If CDRS was in the new Hubs that would give helpful continuity of care." IH referrer, GP

"As we develop the hubs we need to think about pathways into CDRS and why there are different pathways for in hours and out of hours. If we get access and referral pathways right the hubs can be Mental Health for Wellbeing hubs.

Everyone could have access to CDRS but we need to sort the funding out. It works okay now but as we move forward and other services like the hubs come on board, it needs to be reviewed." Stakeholder

Sustainability of funding for CDRS

Each strand of the CDRS has been funded by different sources and the mental health/distress landscape is one which has changed already since the service was commissioned and will change further in the short term. If CDRS was more embedded with other services, including co-location for at least some staff, this was perceived to be a means of securing and potentially growing the service to meet the needs of local people.

"My main concern is where the funding sits - is this sustainable? And if numbers increase can they still keep delivering such an amazing service?" IH referrer, GP

5.15.8 Standardising access for different referrers

Inconsistencies between the OOH and IH services were highlighted by referrers, such as very different response times and the fact that it was perceived that patients could self-refer to OOH but not IH. Consistency was sought, with open access alongside one telephone number so that referrers could refer whenever suited them and speak to someone rather than an answer machine if out of that service's hours. This was seen to reduce barriers for referral and improve the service to individuals. It was understood that the different services are funded differently, but stakeholders felt if there was a reciprocal arrangement, it could work well.

"It would help us if they were seen/spoken to within an hour or at least guaranteed on the same day as that could make a difference. If the response time was more like out of hours there would be more benefit for the patient to be signposted by reception staff." IH referrer, GP

"I know IH is for GPs but it would be helpful if they could be flexible and take referrals from us in hours. There's a bit of flexibility but it would be helpful to clear up any ambiguity." OOH referrer

"The only thing which could be improved would be if we could refer in the day time. We work day and night shifts and it would help if we could refer whenever we have someone who needs the service as it's really beneficial." OOH referrer, MHAU

"MHAUs, Police and Ambulance are also 24/7 and GPs have in and out of hours services, so we don't really want different opening hours or numbers to be a barrier - it's enough to have to think about location." Stakeholder

As CDRS can refer to MHAUs and GPs can use Consult Connect for same day MH service some degree of reciprocity was already seen to be in play. It was also suggested that if Police Scotland referred to CDRS during the day and needed clinical input, CDRS could refer to MHAU so GPs do not need to make that decision, making more streamlined and quicker access to support.

5.15.9 Developing the relationship with DBI

Whilst many front line referrers were not aware of the DBI, other stakeholders were very aware that DBI is high on the agenda for the Scottish Government and CDRS needs to take cognisance of this as it operates in the same space. Glasgow is a large city so there was perceived to be space for two services, provided their roles, remits and referral pathways are clear and they work collaboratively. There was concern however that, as DBI is a national initiative supported by the Scottish Government, a local solution may find itself frozen out particularly if funding tightens. However, GAMH and DBI national team are working in partnership to ensure that both CDRS and DBI operate in Glasgow to maximise the benefit to people who may need the service and referrers.

5.15.10 Increased support for CDRS staff

All CDRS staff members have access to external support from a specialist consultant. This has been delivered largely as a group, four times a year for out of hours staff and three times for in hours staff. If required, individual ad hoc sessions can be arranged and at the time of evaluation this had happened on one occasion. Support is also provided via team members and leadership on a day to day basis.

Given the complexity of the cases which come to CDRS, particularly to OOH, there may be a case for increasing the support provided to staff members and to make individual support a standard rather than exceptional occurrence, to avoid vicarious trauma. Budget allocation has been a limiting factor to date but the amplified needs of people seeking support was also a heavier load than expected.

There has been some churn of staff, particularly in the OOH service - which may well be due to other factors – but it may be helpful to assess the ways in which staff are supported to deal with the cases they encounter to minimise the impacts on the team as individuals and staff turnover. This type of role might be expected to be limited to three or four years before a change of focus, because of the toll the caseload can take on those providing support, but more rapid turnover of staff may suggest the role is not for them or they need further support. There may also be unmet training needs for people new into post, which can have an impact on others in the team. Again, the commissioning budget of the service may have been inadequate to properly support and develop the service and its staff, but now that the service is operational future budget allocation should better reflect what is required.

Another aspect of support for CDRS staff is administrative support. There is a fair amount of admin in terms of logging referrals, updating progress, finding and emailing out resources and generating the weekly reports. It was suggested that dedicated admin support may be helpful, particularly if referrals increase.

5.15.11 Training referral agencies

It was suggested that there is a role for CDRS, and perhaps MHAU, to be involved in training Police officers on when it is safe to leave people at home rather than bring them to A&E/MHAU and when CDRS is a more appropriate direct route.

5.15.12 Maximising use of the website

One CLW suggested that free resources such as coping strategies, diversionary strategies, what is anxiety and how to deal with it, etc., on the CDRS website may be helpful. It is noted that there are already some links to resources on the GAMH website but this could be expanded to include the tools the CDRS team find particularly useful. It is important to recognise that people in distress may not seek information out, although others may do so on their behalf, and may not utilise it without guidance.

5.15.13 Group work

Bringing the CDRS skill set to a group work setting was also suggested by a couple of in hours referrers. Peers sharing knowledge around coping skills for example, in communities was seen to be a positive preventative approach.

5.15.14 More!

Several stakeholders felt CDRS was doing the right thing in the right ways, but they would perhaps like to see more or longer support for people.

"I've had four sessions so I know I'm getting to the end. It would be good to have say 8 sessions to really make sure you're stabilised though." Person who engaged with CDRS

"I would like to see [IH] extend to more appointments - 3 to 6 - but there's nothing else to improve. All the feedback is great, techniques are good and CDRS is the only service with such a quick turnaround. I would be struggling if not for this." IH referrer

"I don't know how long they're in contact for but it could probably be extended so people have more time. It depends on the premise of the service but people always need more time!" IH referrer, GP

5.15.15 Extending hours and age groups

Later working hours *"into the night"* was also suggested as a possible improvement by a couple of OOH referrers on the basis that it is a *"wonderful service"* but by the time patients are assessed (which usually takes around an hour) at MHAU, it can be quite late by the time a referral to CDRS is made. That said, most MHAU stakeholders highlighted peak times for distress did coincide with current CDRS OOH opening hours so the number of referrals may not justify this at present.

Day time at the weekend was also highlighted as not being covered at the moment, which gives potential scope for expansion if the number of people in distress with potential referrers justifies that (now or in the future).

A few respondents also highlighted the particular needs of younger people, particularly given the waiting times for CAMHS support, so it was suggested by a couple of stakeholders that the age criteria for CDRS was reduced to 12+. CDRS has recently established a separate service for young people but this is targeted at 16-25 year olds only at present.

5.15.16 Refresh of the database

Given the point raised under challenges, it may also be helpful to have a fresh look at the CDRS database now that it has been operational for a while to ensure usability is optimised and the correct information is being collected in the most useful way(s) in order to help report on progress and develop the narrative of the service.

5.15.17 Better equalities representation within the teams

All CDRS are well qualified to perform their role, but sometimes people would prefer to engage with someone of a particular gender or ethnicity, for example. The staff team is largely, but not exclusively, white and female so this could be improved upon to ensure there is always choice for people and to ensure a mix of perspectives and experiences to draw upon. There is a reasonable age spread, although the IH team is younger on average than the OOH team.

5.16 Sustainability

All 70 people who gave their views on CDRS would like to see it continue providing a service in Glasgow. There was **emphatic** support for CDRS and genuine concern about the real loss it would represent to people in distress and services referring to CDRS if it was not sustained. This was the case for both the out of hours and in hours services as the quotes below illustrate.

"It should definitely continue. The service is a lot quicker than other mental health services but it is very short so it's not like other mental health services. I was so surprised when I got the first call so quickly - wow!" Person engaged with CDRS

"Absolutely! It was good to know that someone cared." Person engaged with CDRS

"100%. It's too important not to be there, to let it go. You can't get that from friends and family, you need an anonymous avenue to go down, especially after lockdown. I hope it gets all the funding in the world" Person who engaged with CDRS

"Absolutely! It would be a great loss if it went. With Covid, mental health issues have gone through the roof. There are different problems now with finances/debts and people worrying about how they'll pay their bills, especially if they're working. That's not going anywhere." Stakeholder

"GAMH has done incredibly well to get the service up and running so it would be a shame for them not to be funded [in future, as other services develop]." Stakeholder

"Yes, 100% I want it to continue!" IH referrer, GP

"This is a brilliant service. Don't you dare take it away!" IH referrer, GP

"I wouldn't want to lose it! It's such a valuable service, very helpful and refreshing, very different to community mental health teams. It's a positive experience, which complements but is very different to mental health services in a clinical setting. It gives people time to breath and talk at their own pace, its invaluable. With the pressures on mainstream services you lose that." IH referrer, GP

"My experience has been first class and colleagues have said the same thing. The team is very professional, I've been very impressed and it's a very useful service so I want to see it continue!" OOH referrer

"I can't stress enough how invaluable and very easy/quick it is to use CDRS. It's now embedded in our service and is 'our go to'. It's a prime example of how well it has worked and we value the service." OOH referrer, MHAU

"100% it should continue. I would be gutted if it went - it would take away a great option for me. 20-30% of people I see, I refer to CDRS. I'm very thankful for the service, I genuinely appreciate what they do. It makes my life easier and it's better for patients." OOH referrer, MHAU

"YES! I want it to continue. We'd be lost now without CDRS, they play such an important role in our work." OOH referrer, MHAU

6 Impacts

6.1 Introduction

The critical point of any service is whether or not it makes a positive difference to the people it serves. This section aims to convey how the support from the CDRS teams made people who were distressed feel and what tangible differences it made to them. The impacts on those referring are then illustrated, followed by contextual information around costs and comparative value of the service.

6.2 People using the service

6.2.1 Making a difference

Whilst only a small number of people who used the service gave their views directly, those discussions were extremely powerful. People of different ages, stages, genders and background were interviewed and all were very positive about the support they had received from the CDRS. There was a genuine sense that it had made a significant and positive difference to them in their time of distress. This may not be the case for all people referred, but the non-judgemental, compassionate response from staff in both OOH and IH services was hugely appreciated. CDRS staff were praised for encouraging people to share their stories, fears and dilemmas – from their past, present or future.

> *"The minute I heard her voice I felt calm and knew I could talk to that person."* Person who engaged with CDRS

> *"All the practical help was so valuable, I can't repay what they've done for me. I don't have the words to show how grateful I am. I was so distressed but [CDRS staff member] was so reassuring and helped me to see things as they should be not how I was. I've got to start living. I hear her voice telling me what to say or do like a fairy godmother."* Person who engaged with CDRS

> *"This was the right place for me, where I was meant to be. I couldn't open up to other people."* Person who engaged with CDRS

Referrers also reported positive feedback from patients. Those referring to IH were more likely to have an ongoing relationship with the person who was referred than those referred to OOH, but some people were frequent visitors to MHAU, for example.

> *"It definitely has an impact on patients. It's another support service, especially for those who are socially isolated."* IH referrer, GP

> *"I occasionally see people I've referred before and no-one didn't rave about it, to be honest. They are so impressed that they get a call so quickly and then regular support with signposting to other services if appropriate."* OOH referrer, MHAU

> *"Talking is the best therapy!"* IH referrer, GP

6.2.2 Feeling better

The short version of the impact achieved is that CDRS helped people to feel better… about themselves and the circumstances in which they have found themselves. People presenting in distress often do not have mental health issues, although some do. The issues people are presenting with – bereavement, loneliness, relationship issues, debt, current or historical abuse and trauma, criminal justice involvement (either as victim or perpetrator), addictions issues, work or housing problems – are all things which it is perfectly normal to feel distressed about.

CDRS helps to normalise those feelings and helps people, and sometimes their families, to cope with them. People reported feeling heard, treated with compassion and felt safely *"held"* by the CDRS team. They also reported feeling supported, cared for and motivated to take steps to improve their wellbeing.

> *"I felt swaddled like a baby."* Person who engaged with CDRS
>
> *"They made me feel better, more prepared."* Person who engaged with CDRS
>
> *"It was good to have someone outside the situation."* Person who engaged with CDRS
>
> *"I'm sleeping better."* Person who engaged with CDRS
>
> *"It was good to have to get dressed to come in here, having a reason to get dressed."* Person who engaged with CDRS
>
> *"It makes you feel safe again and that there is a light at the end of the tunnel. There's always a way out. The staff are so caring, they really want to help you and it feels like they genuinely care for you. They mean so much to us as a family."* Person who engaged with CDRS
>
> *"At the start I needed to get a lot off my chest but I could slowly see the progress. By the time we had the last call I felt great! We usually spoke for an hour or an hour and a half and that was only 15 minutes. I had nothing to say, I just felt really good."* Person who engaged with CDRS
>
> *"I've had very good feedback from patients. For example, going from a 9 to a 4 on the distress scale."* IH referrer
>
> *"It tangibly helps, especially if something is going on for people in the moment, for example if they've lost someone. It helps my relationship with patients too because I've put them on to a good service."* IH referrer
>
> *"CDRS is my go-to. It works and they're a lovely bunch."* OOH referrer, MHAU

Suicide and self-harm deterrent

Those who had engaged in suicidal ideation and/or self-harm also reported positive shifts in their thoughts and behaviours.

> *"If it wasn't for [CDRS] I wouldn't be here today. I had nothing to help me get through it. I don't know how I would live without them, they were piecing my life back together for me."* Person who engaged with CDRS
>
> *"I've not self-harmed since."* Person who engaged with CDRS
>
> *"They gave me their time. It made me feel worthy, especially if I was feeling suicidal or depressed. It was nice to have a phone call, it made me feel better. I spoke about a lot of stuff, really opened up. I didn't want it to end."* Person who engaged with CDRS

CDRS was seen to take safety planning very seriously. One person using the service had overdosed twice before and not had any safety planning afterwards, but as soon as they shared their thoughts, CDRS met them face to face, agreed a safety plan with them and provided information on sources of support.

6.2.3 Immediate relief

The immediate relief of the service was evident as people reported feeling listened to, taken seriously and looked after. Moreover, this was someone reliable and trusted who called when they said they were going to call.

> *"It was good to have someone who listened and understood, it felt like they had my back… They also called when they said they were going to call!"* Person who engaged with CDRS

> *"It's just a great service. It was exactly what I needed at the time and I wouldn't change anything."* Person who engaged with CDRS

> *"I needed someone to talk to and listen to me who wasn't in my immediate family. It was exactly what I needed.* Person who engaged with CDRS

> *"Patients are well looked after so they do feel safe to work through things with CDRS."* IH referrer

> *"I don't have much time so it's very helpful to know that patients are being supported with interventions and signposting so I can focus on other things with them. It's key that they get this support quickly to make a difference."* IH referrer

> *"Patient feedback is very good - a good service at the time they need it. With other MH referrals we get a lot of bounce backs. A lot of patients have no confidence in CMHT but they do have confidence in CDRS."* IH referrer, GP

> *"It does have an immediate effect on patients, they feel supported."* OOH referrer, MHAU

> *"If someone is in crisis they really need an immediate level of support but there are waiting lists for NHS treatment. It's music to their ears to find this service that can see them straight away."* OOH referrer, MHAU

6.2.4 Longer-term impacts

Some medium to longer-term impacts were also noted, such as learning to use particular tools or techniques when people felt they were becoming distressed or feeling anxious, to help them manage the shift to a more positive frame of mind themselves. This improved self-awareness, understanding and self-management via using tools etc helps people to work independently through a preventative process. It may also help people to seek help earlier if required. Tools which were mentioned particularly positively included soothing boxes, breathing techniques, introduction to mindfulness, grounding techniques, de-catastrophising and sleep strategies in addition to learning how to identify, process feelings and manage their emotions better.

> *"It was really helpful and there's a preventative side, I have more skills now so I'm able to manage better."* Person who engaged with CDRS

> *"It leaves a legacy. I can use the box when I need it. I would use the tools first and if I felt I wasn't getting anywhere on my own and I needed a boost I would get help from CDRS again."* Person who engaged with CDRS

> *"It really helped me. The listening and the coping skills, helped me to ground myself. That was immeasurably helpful. It was definitely useful at the time and I do still use them."* Person who engaged with CDRS

> *"It has a short and long term impact. I use these tools daily and will keep doing so. They helped me deal with something else - I regulated my breathing and I coped."* Person who engaged with CDRS

"I think everyone should come to something like this and learn these skills. It's helpful and has a preventative side. Kids should learn about it." Person who engaged with CDRS

"Compassion has a long term impact. If a patient feels heard and is given stuff to work on they don't forget quickly, that impact continues." IH referrer

"It gives them [patients] some sort of outlet, it offloads how they're feeling. It's short but if they remember to do it or practice the tools they've been given it helps." IH referrer

"Patients found it [CDRS] to be of benefit. They enjoyed speaking, being heard and the coping or grounding tools helped them day to day. I will use the techniques with patients myself if they're open to it but if they're not taking it on or need something next level for a few days I refer on to CDRS." IH referrer

"I always speak to patients afterwards and ask how it went. CDRS gets really good feedback, which gives me confidence to refer others. I've not had any negative feedback at all. It's not just hand-holding or a chat, it's practical and emotional support. Patients do take away something from the interaction and even though it's a short-term service the take away impacts can be longer lasting." IH referrer

"The tools they teach patients, like breathing or relaxation exercises are helpful so they can do them when they need to and they seem to enjoy them." IH referrer, GP

"It's what people want - CDRS listens to them helps them with coping skills and support them with a listening ear and follow them up to see how they are." OOH referrer, MHAU

This was also cited in relation to helping people overcome their immediate distress and cope whilst waiting for access to another service.

"Some need a wee bit of extra support now while they're waiting for something else to happen. It bridges the gap before other services start and CDRS can suggest other services and teach them relaxation techniques, breathing exercises and things like that to help people cope." IH referrer

"[CDRS] are the only ones to offer this kind of service - immediate support when people need it. I'll sometimes use it as a stop gap if they need something before they can access another service, in a planned way or if they don't improve they get back to me." IH referrer

However, it was recognised by referrers and CDRS staff that some people will not practice techniques without supervision, either because they forget (to do them at all or how to do them) or because they are overwhelmed. Some people who used the service felt having the scheduled call made them action whatever they were meant to be trying out so they didn't let the CDRS staff member down or so they didn't feel like they had not done their 'homework'. This provided useful motivation for them.

"I was doing small things to keep my mind healthy, like working out. That was a good suggestion, I hadn't thought of that. It was useful to have that conversation and the next meeting to push me to do stuff, so I could say I went for a run or cooked food, went outside or whatever. It was motivational." Person who engaged with CDRS

A couple of IH referrers highlighted how useful it can be to refer patients more than once if they need a short but intensive period of support to get them over a bad patch, particularly for those patients who have particularly challenging or chaotic lives.

> *"I have a guy with severe mental health problems I've referred three times. He gets down and feels very suicidal. He needs someone to talk to and then he's okay. He thinks they're great [CDRS] and says they help him greatly, so I know they have a really positive impact on him and he's very grateful for their help. I know he needs that bit more than I can give him for a couple of days."* IH referrer

Other felt it was unlikely for people to have longer term impacts – certainly for some issues underlying the distress - but could see the short-term impact on their patients.

> *"It has a short and medium term impact, I know they've been helped. Probably not a longer term impact [if their situation can't be improved]."* IH referrer, GP

> *"I don't think it will help in the medium or longer term but CDRS is very good at helping patients to manage their acute distress or crisis in a short space of time. I've had a very positive response from patients."* IH referrer, GP

6.2.5 Making progress through small goals

People in distress often have a number of things going on and this can feel overwhelming – where do they start? The CDRS teams work with people to break things down into the more pressing and important, and support them to deal with these first. They also cover basics like whether they are eating well, sleeping properly and getting fresh air and exercise. They provide information on sleep hygiene factors and try to get people into a 'normal' routine of getting up, washed and dressed, cooking a pot of soup, going out for a walk, etc. Setting and meeting small goals or 'baby steps' in this way shows people that they can make progress and quickly start to feel better, which helps them to tackle the more difficult steps.

Feeling 'more like themselves' can sometimes help people to open up about historical issues they have never addressed and CDRS can hear their story and ensure they have appropriate support. Helping people to get into a better routine can also help them to build bridges with family and friends, which can be very positive for the individuals and their loved ones.

6.2.6 Signposting to other services

CDRS works to alleviate distress from day one but also considers the whole person, what brought them to feel such distress and what interests or community supports might help them on an ongoing basis in a preventative sense.

> *"Everyone who has given me any feedback on CDRS has said it's great, really good. They obviously feel supported. It gets people over that 'hump' when they have a crisis for a couple of days. It has a short term impact but also a longer term impact. For example, you find out they've put someone in touch with other services like they've joined a befrienders service."* IH referrer

> *"Yes, it is short but patient feedback is very positive. One was sent on a workshop for anxiety that helped."* IH referrer

> *"It [CDRS] makes a difference to people. They provide reassurance, someone to talk to when they need it, they know they're not alone, they can be referred to relevant services. That's all really important for a lot of patients."* OOH referrer, MHAU

6.2.7 Preparation for other interventions

The fact that CDRS helps people to talk about their thoughts and feelings was also highlighted as an important preparatory stage to enable them to engage more readily with other services, such as specialist counselling or trauma services. So, CDRS is not just perceived to be about alleviating distress in the short term or 'babysitting' while people are waiting for another referral, but also doing preparatory work for that service.

> *"[CDRS] is a quick, responsive service for people in distress or with mental health or trauma issues. There are long waiting lists but people need to be ready to engage with the Moira Anderson Foundation or whatever as they don't always have that many sessions and they need to make the most of them from the start."* IH referrer

> *"If people are in distress they're not ready for CBT, but if you can deal with the distress they might benefit from other services in the longer term. They need to be held, to talk and for someone to listen. That's CDRS."* IH referrer, GP

6.3 Referrers

6.3.1 All referrers

Peace of mind

Impacts varied slightly for different referrers, but there were common themes which emerged from discussions. Those referring to CDRS were hugely appreciative that they could do so as there was no alternative service and they felt confident that people would be supported by the team. This helped referrers feel they were able to do something – with a rapid response - to help people who were in distress, as they wanted to help and feel that people could be supported to a more positive position. It gave them peace of mind, effectively. Before CDRS came into play, referrers were frustrated that there was nowhere to refer people in distress to so either had to spend time they did not have to try to support them or feel worried about leaving them without support.

> *"Saving time is not my aim in referring. It makes me feel happier, feel safer that the patient has another point of contact who is better placed to deal with their emotions or the situation they're facing."* IH referrer, GP

> *"It takes the stress off my role. I can refer and not worry about them [patients] getting support. It's good to know it's there. I've phoned them for advice a couple of times too."* IH referrer

> *"They do respond quickly, I know they will do it. It's great to have the confidence to promise patients they will be in touch."* IH referrer

> *"It gives me peace of mind if I can refer people to CDRS. You can never guarantee people's safety 100% and that's the hardest thing. All the patients find it beneficial, our regulars think it's a great service."* OOH referrer, MHAU

Making their job easier

As well as giving them peace of mind, being able to refer people who did not merit a clinical response to another service – for immediate support – makes life easier for referrers. It means they have something to offer people in distress rather than nothing.

> *"It would make my job 75% harder if CDRS wasn't there. I can discharge patients knowing they are going to get help." OOH referrer, MHAU*

> *"5pm to 2am is really crucial for our service." OOH referrer, MHAU*

"It makes life so much easier in our job, really so much easier. I regularly refer to CMHT for an urgent 5 day referral and during that period I often refer to CDRS to cover the gap, which can be very beneficial." OOH referrer, MHAU

"Absolutely, it gives me a plan to offer patients for additional support with a professional service and they've given us clear guidelines on how we can explain it to patients. People may also have historical awareness of GAMH services, which offers something different to mainstream psychological services with emotional support and signposting to relevant services." OOH referrer

Good timing

The timing of CDRS starting just after Covid-19 appeared was also cited by referrers as a benefit for themselves and the people they referred. This was particularly for those who did not have a mental health diagnosis.

"We obviously see what people's issues are and refer where they think they will have the greatest benefit. Not everyone has a mental health problem. For example, when we were in lockdown older people, particularly if they were shielding, were isolated and frightened so CDRS was a lifesaver [for them and me] at that time. Issues change all the time." IH referrer

Interim support

Both OOH and IH referrers, albeit more of the latter, refer patients to CDRS for immediate support and to improve coping skills while they are waiting for referral to another service. This helps the patient cope better and helps the referrer feel like they are able to provide help when the person needs rather than *"in two years or whatever"* as some services have extensive waiting lists which have only been exacerbated by the pandemic. It may also help prime the person to be ready for engaging with another more intensive service.

"It's even helpful for people with mental health problems, if they've exhausted everywhere else it's good to know there's somewhere else to turn. It's also good to refer to CDRS while they're waiting for counselling. It's a two year wait for Sandyford for example at the moment. Everywhere has a waiting list. I can call people once a month or every two or three months, say, but not more and CDRS can really help them manage that wait." IH referrer

"It fills a gap in a lot of ways, for example a number of times I've referred to CDRS when there's a waiting list for another service and its distressing for patients. CDRS get to know the person and understand the issues so they're then ready to engage with the other service. It works very well." OOH referrer, MHAU

Collaboration and knowledge

The ability to discuss people's care needs with CDRS staff, who were felt to understand the people they supported and the wider system, was appreciated by referrers. CDRS knowledge of other services and supports in the community was also appreciated by referrers, both in and out of hours.

"They're also useful for us as it's another professional to discuss care with, which is really beneficial. They're also aware of other services that we don't know about, so we can signpost people." OOH referrer, MHAU

6.3.2 OOH service

The right service

If mental health services – scheduled or unscheduled – are not what a patient needs, CDRS has filled a gap for clinicians to refer people for appropriate support.

"CDRS is really crucial to the whole agenda around unscheduled mental health care… we see a lot of people in distress at unscheduled care and need to find them

support. CDRS is the right service for that support or people will be on the waiting list for a service when they shouldn't be… We would struggle without that [CDRS] to meet people's needs. It's very important to have follow up support for people [with low MH needs/high distress]." Stakeholder

"It's a lifeline for patients and us. If people are in distress we're limited in what we can do - no meds or psychological interventions but they need something to help them immediately. CMHT often won't respond quickly and people are disappointed if they don't qualify at all but we feel safer offering something [CDRS]." OOH referrer, MHAU

Reducing contact with frequent callers

Whilst OOH referrers often do not have more than one interface with a patient, it was clear that some individuals call or seek assistance from MHAU, NHS24, Police or Ambulance on a regular basis. The anecdotal feedback would suggest that support from CDRS reduced the number and/or frequency of calls at least while engaged with CDRS, as these could be nightly without that support.

6.3.3 IH service

Saving time

CDRS was perceived to save time for GPs, as had been hoped when the service was commissioned. This was down to two different aspects: as they had confidence that patients were being supported GPs felt the need to be in touch less often, and it also helped to reduce the length of some initial discussions as the GP had somewhere to refer people on to. Saving time was also apparent for Community Links Workers and Mental Health nurses who refer to CDRS.

"If I can refer to CDRS, it saves me time. It's doesn't need to be a long appointment, listening to something I can't fix. I can direct them to CDRS and it saves me time every week. I also feel secure knowing that the patient is connecting with CDRS and they will be well supported, not struggling until I review them again." IH referrer

"It alleviates a lot of the immediate pressure off me. They get the headspace and support then come back to me for other things if they need to. CDRS shares the load and cuts down on appointments with the GP as well as me." IH referrer, CLW

"It does save us time." IH referrer, GP

"It reduces my stress a lot as it's something I can actually do to help someone. A lot of time I don't have half an hour to give them, just 10 minutes so I would need to call them back after I finished. That's up to an hour listening then every fortnight or so to see how they are but if I know they're being supported I speak to them less often, say every 1 or 2 months, and less prescribing, or I'd be quicker to lower the dose of benzos… and felt I could help." IH referrer, GP

"It's undoubtedly time saving. It's less than a 5 minute call, I mention the service and refer them on." IH referrer, GP

"I can do a 10-15 minute chat then refer to CDRS, instead of a 45 minute chat and still not have anywhere to send them [so would have to hold onto them/see them]." IH referrer, GP

"It's almost magical that there is an immediate response and no barriers to referral. It saves time and has an impact on our own mental wellbeing as we know they're going to speak to someone today or tomorrow, no worries. It's draining as distress is such a frequent or standard event, another reason for burnout." IH referrer, GP

"Patients aren't signposted from the desk, I still usually have a long conversation then refer to CDRS but it reduces the number and length of follow up sessions. For example, I can call back in two to three weeks rather than one week and conversations are generally shorter." IH referrer, GP

"It makes a big difference to me knowing that my patient is being supported. It's not a psych issue but it's a good experience the patient has liked. CDRS is very prompt and I'm confident that they have helped. They provide a safety net… Yes, it has saved me time because I've not seen them as much so maybe one or two appointments saved." IH referrer, GP

"I maybe save 15 minutes per patient, so 30 mins a week. The main benefit is that the impact on the patient can be immense. [CDRS] go the extra mile." IH referrer, GP

One GP group felt it was difficult to say if there was a time saving from referring to CDRS as they felt they still see these patients as they like talking to their GPs! The group felt there may be more of a time saving if CDRS was able to link better to other mental health services rather than refer them back to the GP for onward referral.

Reducing medication

Whilst a reduction in medication was not perceived to be a key aim of engagement/referral to CDRS, a few in hours referrers wondered if this might contribute towards a reduction to a small degree – as an alternative to medication to be offered, or wellbeing improvements to help with quicker reduction of levels - but they did not tend to have a definitive view on this.

"It's made my job easier. When I refer I feel content that they'll be reassured and find it useful to speak to someone… It saves me time as I have fewer calls back and fewer referrals to other services. I don't know about meds, maybe. A lot of patients will say' a couple of Valium and I'll be fine' but I don't just give out meds unless necessary. I suggest we try this [CDRS] instead and we can rethink meds at another time. It stops them feeling Valium is the only thing they've got." IH referrer,

6.4 Costs and value

6.4.1 Introduction

This evaluation does not aim to conduct a detailed cost benefit analysis or social return on investment calculation. However, it might be helpful to consider costs of the CDRS service in relation to potential savings – particularly as this was such a huge issue for GPs prior to commissioning – and the value achieved in terms of impacts on people using the service.

6.4.2 Costs

Looking firstly at costs, this is a fairly simplistic approach to provide a sense of costs at current referral and engagement rates. The following points should be noted:

1. Indicative costs per contact/referral are based on budgets set for each service rather than actual costs. The total budget also includes overheads, annual leave, etc., and the budget may be higher or lower than the actual spend in reality.
2. The average number of referrals per month is based on June '21 to January '22 once both services were up to speed: 120 for OOH and 235 for IH. However, it is noted that referrals are reported to have increased since then so that would reduce costs per contact/referral further.
3. The cost per average call minute is noted for information. Obviously, not all CDRS work is telephone based as they have team briefings/de-briefs, take referrals, research appropriate

information for individuals, give feedback to referrers, as well as the usual admin, training, and various other tasks.

4. The Out of Hours service was commissioned prior to the In Hours service, which was an extension of the contract. The Out of Hours service was front-loaded with core costs, to an extent, which makes the In Hours service look cheaper than it would be if commissioned in isolation.
5. The Out of Hours service also operates at unsociable hours seven days a week, so incurs higher costs because of that.
6. Calculations also do not take into account the capacity of each service – so if there is capacity to support more people, the cost per contact/referral would obviously reduce.
7. **Most importantly, as the data throughout the report highlights, the nature of the referrals to each service is different, with more intensive support (more calls, longer calls, longer contact) required out of hours for a lower number of referrals in comparison to the IH service and this is reflected in the costs.**

Indicative costs are therefore offered below as ballpark figures within the context of the above caveats.

Table 10: Indication of costs per referral/call

	Out of Hours	In Hours
Cost per contact	£21.53	£9.95
Cost per average call minute	£2.70	£1.62

The cost per contact is £21.53 for OOH and £9.95 for the IH service. For information, the minimal cost of attendance at A&E is £77[38] and a more complex investigation/treatment starts from £359. This source also cites the cost of an ambulance without a visit to A&E as £206 and with a visit to A&E as £292. Missed appointments with NHS clinics are often quoted as costing £135. CDRS support looks very cost effective in comparison.

6.4.3 Savings

The research which was conducted in 2020 and prompted the extension of the service to include in hours referrals from GPs, considered time spent by GPs on patients in distress. This showed a financial, as well as moral, case for an effective, holistic response to distress in a non-medical way to help patients and reduce the burden on general practice. The estimates given by GPs were used to produce a low, mean and highest estimate of cost of GP time only (not full costs, salary only using average salary rates). These were:

Lowest time estimate suggests a cost of £1.9million.
Mean time estimate suggests a cost of £3.9million.
Highest time estimate suggests a cost of £8.0million.

Even saving half an hour per month per member of staff, the estimated basic salary saving was estimated to be **£290k**. This figure is still relevant to consider now given that 88% of GPs/at least 94% of practices have referred to CDRS at least once and some larger practices and/or those in more deprived areas have been prolific referrers. The budget for IH CDRS is just over half of this, so significantly lower.

Looking at this from another angle, GPs were asked to estimate how much time they saved as a result of being able to refer to CDRS. Some found this challenging to calculate as cases varied so much, but low, medium and high estimates of the impacts were made based on those who could provide an estimate. Time savings were perceived to impact on the initial consultation time and fewer/shorter follow up calls. For example, some felt they would save a great deal of time by providing the 'solution' of CDRS to the patient early on in the conversation so they saved a considerable amount of time (e.g. 40 minutes), whilst others felt they would still have a long initial

[38] Key facts and figures about the NHS | The King's Fund (kingsfund.org.uk)

conversation, albeit saving 5 or 10 minutes, but would not then make as many or as long follow up calls as the person was being supported by CDRS.

The lower estimated time saving equates to **£63k** per annum[39].
The medium estimated time saving equates to **£105k** per annum.
The high estimated time saving equates to **£209k** per annum.

Again, this looks positive in relation to the cost of delivering the In Hours CDRS, particularly as impact on time saved by GP is only one of the impacts registered. The costs of referrals equate to a couple of GP appointments and this was at the lower end of time saved for those who were able to estimate this.

OOH referrers also felt their service and others will have saved time by referring to CDRS but this was harder for them to quantify.

It may be helpful to consider the basic salary of CDRS staff in comparison to NHS staff (not including overtime, other benefits or full costs), which again illustrates a more cost-effective approach per staff hour:

Staff role	Basic salary per hour[40]
CDRS team	£12.09
Band 5, e.g. entry level Mental Health Nurse, Counsellor	£13.84 - £16.84
Band 6, e.g. Paramedic, Mental health nurse specialist, Counsellor, Trainee Psychologist	£17.24 - £20.76
Band 7, e.g. Clinical Psychologist, Art Therapist	£21.31 - £24.38

6.4.4 Value of the service

It is important to state that, whilst GPs were keen to see time savings and have greater peace of mind themselves, they felt the most important factor was to support the reduction of distress their patients were experiencing. There was also a hope that for at least some patients there may a preventative influence from increased resilience and coping skills. These represent the real value of the service for many GPs and their teams.

CDRS was not designed specifically as a suicide prevention service but both IH and OOH services have worked with people who were/are actively suicidal. Feedback from people supported by CDRS suggests that without support from CDRS they think they would have completed suicide. There is no way of knowing this for sure, of course, and it is always difficult to measure what has not happened.

Valuing a person's life is an ethical and moral minefield, where many factors can come into play. There are many different approaches to doing this and Social Value UK has written about these[41]. Their summary includes an average cost of a completed suicide which was calculated by the Department of Health, Social Services and Public Safety in Northern Ireland. This was estimated to be around £1.7million, including direct and indirect costs and the intangible costs of the impacts on the victims and families.

For other people who have been supported by CDRS, the impacts have been both intangible - feeling better, more hopeful, more engaged in life, relationships and communities - and tangible. People have been referred on or signposted to services which have helped them address trauma

[39] On the basis that low total time saving per referral is 30 mins, medium is 50 mins and high is 100 min; number of referrals pa were 2,510 (to account for non-contact by CDRS); and using average salary rates with NIC added only, not full cost of employment, i.e. a rate of £50/hour. Other sources such as the one above cites a 9 min GP consultation as costing £39.23 or a missed GP appointment costing £30, so these costs could be significantly under-played.
[40] Pay scales for 2022/23 | NHS Employers
[41] Valuation-of-a-life-1.pdf (socialvalueuk.org)

and/or abuse, problems with benefits, debts or housing have been moved forward positively and some have been able to reconcile with their families.

One of the key support mechanisms provided by CDRS has been supporting people to identify, normalise and deal with their thoughts and feelings. Sharing tools and techniques to cope when distressed, even if not universally adopted in future, helps to build resilience, lessens the likelihood of distress in future and the current/future load on a wide range of health and other services in addition to enriching the individual's life and those of their families and friends. This is priceless.

7 Concluding comments

7.1 Introduction

This evaluation has tapped into the views of 70 stakeholders, reviewed project data and considered the context for the Compassionate Distress Response Service. The key take-aways from the evaluation are:

- The CDRS – both In Hours and Out of Hours – is perceived to be much-needed by people engaging with the service and referring agencies.
- It is seen to be providing an excellent level of care which is making a positive difference to both the people it supports and referrers, including time/cost savings.
- All stakeholders wish to see it continue and to develop to become a sustainable and embedded service supporting the people of Glasgow.

7.2 Revisiting the brief

The brief was to describe and understand the CDRS. This section recaps on the key aspects of this.

7.2.1 Profiling who is accessing the service

The In Hours and Out of Hours services have a similar offer but have a different profile of people accessing the service to date. Both have people engaging from the full age spectrum and presenting with a wide range of issues which are causing them distress. The In Hours service has had more referrals, and has dealt with a higher proportion of women, a slightly older profile and people tend to present with fewer or less complex issues overall. That is not to say that none are, but the complexity and needs of those presenting in distress is clearly more profound Out of Hours, where younger people and more men present. This is perhaps to be expected, as people have come to CDRS via Police/Ambulance/ Emergency Department/MHAU – these are more urgent routes to help and have involved higher proportions of self-harm and suicidal ideation or behaviour.

People engaging in support from Out of Hours were much more likely to have a risk or concern to be aware of (79% OOH; 11% IH), to feel at risk of suicide (64% OOH; 12% IH) or exhibit self-harm behaviours (30% OOH; 5% IH), have issues around drug or alcohol abuse (37% OOH; 4% IH), offending (8% OOH; 1% IH) and violence or aggression (9% OOH; 1% IH). People accessing OOH were also more likely to have had prior contact with the Police (21%), be currently engaged with mental health services (17%), have health issues and be on medication.

The issues people were presenting with usually came in multiples, with an average of 3.8 issues OOH and 1.4 IH, which were often inter-related. The top issue for both was anxiety and stress, closely followed by suicidal ideation/behaviour in OOH. Family issues, depression, interpersonal/ relationship difficulties, addictions/drugs/alcohol, self-harm, loneliness, trauma, bereavement/loss and abuse/domestic abuse were highlighted by referrals to both services, with higher prevalence for OOH.

The degree of distress for both services is more acute than had been envisaged when the services were commissioned, however, possibly exacerbated by the Covid-19 pandemic and more recently by the cost of living crisis.

7.2.2 Understanding the access pathways

Access for the IH service is more straightforward and is already well established. Only general practice can refer and 88% of all GPs/at least 94% of practices in Glasgow City have referred at least one patient to IH CDRS to date. This can come direct from the GP, Community Links

Worker, Mental Health Nurse or administrative staff (directly or on behalf of a colleague)[42]. In Hours CDRS aims to attempt to make contact with each referral within 24 hours, although most are contacted the same day.

The OOH service was intended to take direct referrals from Police Scotland, Scottish Ambulance Service, Emergency Departments, Psychiatric Liaison, OOH GPs, OOH CPN, etc. but the Covid-19 pandemic hit just as it was commissioned and MHAUs were established. Police Scotland and SAS have therefore taken people in distress direct to MHAUs/EDs so MHAUs are the biggest referrers to OOH CDRS. Referrals were generally slower to build than had been expected. The complexity of cases has meant that each individual has needed more support than expected, however, and some have been particularly intensive.

People in distress have not been able to self-refer to CDRS, so they are reliant on being referred on and CDRS successfully making contact with them as the main medium has been phone engagement, with some limited face to face support and occasional outreach.

7.2.3 Articulating the inputs provided by CDRS

There are the standard process inputs around response times (1hr OOH; 24hrs IH) and number of attempts/calls etc. (usually 6 or 7 attempts OOH; 3 attempts IH), but the key inputs to consider are the ones which were most meaningful to people.

These include the perseverance of CDRS staff to reach people and the time invested but also the genuine listening and interest taken. The useful suggestions of tools or techniques which might help and actually practising these with people to encourage them to test them out and try again in their own time.

The speed of response is a huge benefit for both referrers and referred – when in distress, support is needed NOW and CDRS get as close to 'now' as possible.

The response is seen to be compassionate and person-centred but not judgemental, which was important to people. It wasn't clinical or bureaucratic, individuals drove the agenda for discussion.

Not having to repeat their story - as they had contact with only one or two staff member and staff knew who they were, the names of their children or pets and what they were interested in or what mattered to them - encouraged people to engage with the service. More importantly, this meant people felt cared for and these discussions reminded some of their reasons to live or protective factors.

Starting with the basics – are they safe, sleeping, eating properly, getting some fresh air and moving? - and taking one 'baby step' after another to head in the right direction was very simple but powerful.

Onward referral or signposting to appropriate services – specialist mental health support, befriending or a local community group – also bolstered the support network for individuals.

Some family members were also supported if appropriate too, further illustrating the holistic approach taken by the CDRS team, who assess the wider context (taking into account the needs of three generations in one case).

7.2.4 Understand the outcomes for people using the service

People who used the service reported feeling better and not in 'active distress' following their engagement with CDRS. Some would have liked support for longer to ensure they were more stable, but people reported significant impacts like not completing suicide when that had been their

[42] However, it is often logged as the GP on SCI, so this needs to be taken into account when considering referral rates for individual GPs. For example, a referral from a locum is likely to be logged as coming from a GP partner within the practice.

plan, or reducing self-harm when that was an established habit. Others had found the tools and techniques like a soothing box, breathing or grounding techniques had enabled them to cope better when circumstances were challenging.

They were now better able to identify and manage negative thoughts or feelings and put these into perspective as a normal reaction to events, to prevent or reduce distress in future. Having the opportunity to talk about what they needed to talk about and be heard, by someone outside the situation, helped people to move past the place they found themselves stuck in. People reported re-building relationships and being supported to deal with a range of work, housing or debt problems.

Of course, significant changes will not be the case for all those who are referred to CDRS – some do not engage for a start - and there will be a reducing impact over time to consider but it clearly can make a significant different in the short and possibly medium terms for many.

7.2.5 Understand the referral patterns

Referrals have grown over time and very few referrers noted any slowing down. It is understood that the number of referrals has grown further since the time period analysed from the database and given the cost of living crisis, other local, national and global events and increasing awareness or referrals from new referral sources, this may well continue. Staff and referrers all reported that demand for the service did not have obvious patterns. There are definitely days, weeks and months that are busier than others but this was with a wide variety of issues, different types of people and the feeling was that *"distress just happens when it happens".*

One thing to note is that not all OOH referrals are made during OOH service times. As the IH CDRS only accepts referrals from general practice, MHAUs, EDs, Police, Ambulance, Psychological Liaison and any other OOH referrer – who often work 24/7 – referrals which are made to OOH by answer machine or email will not be picked up until the OOH service commences at 5pm. One OOH staff group did comment on ten new referrals coming in a flurry one Friday and these may well have accrued through that day rather than have been referred as soon as the service started. It might be useful to log the time and day of the week that a referral is made (rather than when logged on the database as these are not all entered immediately), or just the number of referrals waiting for the team at 5pm, to inform future service development.

7.2.6 Describe the costs of the service

Section 6.4 explores indicative costs, potential savings and value achieved and this information needs to be considered with contextual information rather than quoting figures in isolation here. The key message is that CDRS looks like it is providing value for money for commissioners, whilst supporting individuals in distress and those referring them to CDRS. The relatively low cost but high quality of support - considering the greater complexity of cases and amount of support provided, especially out of hours, plus larger than expected numbers of people in distress in hours - taken alongside perceived time saved by GPs, never mind the value of the service in other ways to referrers and people who are supported, suggests this has been money well spent.

Costs may be low per contact or referral but the value of the impacts can be high: at one extreme the cost of a human life saved has been valued at £1.7million, for example. Putting a financial value on being able to cope with distressing circumstances in future, reuniting with family members or sharing with someone for the first time the fact that you have experienced abuse and start the journey to recovery is complex, however.

7.3 Thoughts for future consideration

7.3.1 Continuing the journey

The mental health support landscape is changing rapidly at the moment, nationally and locally, in response to growing and changing demands and their mismatch with current service delivery and resourcing. The new Compassionate Distress Response Service is one of many recent changes and further developments which are coming, such as the pilot hubs and national roll-out of the Distress Brief Intervention.

The issues raised by people in distress have often been serious, complex and difficult for individuals to 'fix' or change without assistance. The fact that they have caused distress is perfectly understandable and a normal response. The CDRS teams can help individuals by listening and supporting them to find tools to help equip them to deal with challenges in future, but it must be remembered that they cannot always fundamentally change the issues causing the distress. Given the higher proportion of referrals from more deprived areas and the challenges currently facing the population in terms of high inflation and significant pressures around fuel costs in particular this winter, allied to health concerns around Covid, other pressures on the NHS and the physical and mental impacts of being cold and/or hungry, it is hard to foresee the numbers of people seeking help from CDRS and other service providers declining in the short term. There is a perceived need and there is a desire to see CDRS continue, by all stakeholders.

7.3.2 Taking stock of structures, staffing and service delivery

The service is currently rated very positively but it is always useful to take stock of how things could be developed further and respond to the ever-changing landscape. Various suggestions have been made by stakeholders and these are all listed in section 5. Some of these are minor tweaks or suggested by a small number of stakeholders but are still helpful to consider. Perhaps the most helpful points to consider are as follows:

A more seamless service?

The current CDRS offer has developed in three distinct funding tranches, for OOH, IH and the young people's service. It provides a service at different times/days of the week for different target groups and/or referral pathways to meet the needs of funding streams. At present, each service is quite distinct, with different staff. There is obviously a shared approach, shared resources and communication across each service to share learning. There are pros and cons to maintaining this distinction versus developing a more seamless service, for GAMH, the staff, people referred to the service and referrers. The status quo perhaps takes a more siloed, protectionist approach which may foster internal competitiveness rather than a unified service if funding and referral numbers/patterns shift in future, whilst a more unified approach may develop less distinct service personalities but could provide a more rounded service and staff team.

Service delivery is moving towards greater partnership working, co-location and the 'no wrong door' approach. This raises considerations for the development of the service in several ways. For example:

- Should there be one telephone number for all services - to make it easier for referrers - and then CDRS can support the person with the right staff at the right time when they 'triage' them on receipt of the referral.
- Should the service be open to all referrers when it is open? MHAUs operate 24/7 and GPs work before 9am and after 5pm so being able to refer whenever the need arises may be helpful. This would also help protect against a glut of OOH referrals at 5pm, with the dual challenges of a one hour response time and existing (17-25 on an average night) call commitments in the diary.
- Should response times be 'smoothed' to be consistent? At present the OOH service aims to respond to a referral within an hour and the IH service within 24 hours. Both often have an initial short conversation to explain the service, gain a sense of how the person is, make

any initial suggestions/signposting and when suits them for their next call. Could, say, a two or three hour deadline be set for that introductory triage call instead?

- Should the staff work across all three services? This would help to bring shared experience/expertise, share the severity of case load and unsociable hours providing a richer experience for people using the service and staff.

Taking partnership working up a notch?

CDRS, GAMH and its funders are all aware that the wider world has changed since CDRS was initially designed and a view needs to be taken on how CDRS can best respond to that. Whilst GAMH, the CDRS team and commissioning teams have worked hard to develop the service, the service needs to be sustainable. There may be opportunities to work more closely or in an integrated way with MHAU and the mental wellbeing hubs. This discussion should go hand in hand with consideration of how referrals from Police Scotland and Scottish Ambulance Service, for example, can be improved as these issues are potentially inter-related. Increasing staff opportunities to get out and meet partners and/or work in different settings, may provide more learning, development and enriching opportunities for all.

The national DBI is also keen to extend its associate programme. The CDRS has been actively developed in response to Glasgow's needs but stands separate to this national direction of travel. Both CDRS and DBI do similar but not exactly the same work and it makes sense to work in tandem rather than in competition, but the funding landscape in particular can be a competitive one, especially if resources are strapped. More than one stakeholder suggested there was space for both CDRS and DBI in Glasgow given the levels of distress, provided the pathways are unambiguous and services work in tandem, with good communications and learning from each other. It was noted that there was currently little awareness or knowledge of the SAMH DBI by many referrers, so there may currently be little crossover between the two services, with referring agencies having a referral pathway for one or the other.

As one stakeholder said: *"We need less competition and more collaboration."*